LOOKING AHEAD:
PHILADELPHIA'S AGING POPULATION IN 2015

JANUARY 2006

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Philadelphia Corporation for Aging

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I.   Introduction

These pages paint a portrait of Philadelphia's aging population by the year 2015 and beyond, drawn from comprehensive data analysis and research commissioned by Philadelphia Corporation for Aging. The picture that emerges is of an increasingly diverse older population – ethnically, racially, economically and in terms of lifestyle, health and well-being. In the year 2015, Philadelphians over the age of 60 will be active and engaged with work, volunteering, social life, grandparenting and caregiving. But a significant proportion will have serious needs in many realms of their lives that may lead to potentially broad-ranging consequences for the region in the decades to come.

Real concerns for the future status of Philadelphia's elderly are raised by the many trends defined in this report relating to income and poverty, health, mental health and disability, housing, community and isolation – especially when these trends are seen in the context of continued cuts in funding for many aging-and poverty-related services. Many of the variables in this potentially corrosive dynamic are outside the control of aging service agencies: government funding, prospects for health care and mental health care reform, and the future of Social Security and the Federal deficit.

However, some important variables in the future status of the region's elderly can be controlled. These include the civic will to plan creatively and collaboratively, to cultivate future organizational and political leadership, and to develop political and community awareness and support for the needs of Philadelphia's aging population.

While this analysis cannot be viewed as comprehensive or predictive, it does depict a foreseeable future for the region's elderly. These data and insights about potential problems are intended as a springboard that will lead to more in depth analysis and planning to strengthen services and supports for Philadelphia's future elderly population.

This report is designed for a diverse readership, including:

- Agencies serving the aging population's needs related to health, mental health, housing, employment, volunteerism, transportation, religion, caregiving, advocacy and social services;

- Politicians, policy-makers and planners at the Philadelphia, regional, state and federal level;

- Foundations seeking to address the current and future needs of Philadelphia's aging community;

- Corporations with a stake in Philadelphia's future;

- Elderly individuals and their families as well as future clients of agencies that serve the aging;

- Reporters for area newspapers, magazines, radio and television stations who may use this document as a reference tool and as background for more in depth reporting on specific trends.

The structure of this report incorporates a unique dimension that provides a human context for the catalogue of comprehensive data from local, regional, statewide and national sources. Whenever possible, comments from focus group participants and from a diverse range of experts on the region's aging population accompany the analysis of each area of concern. These sources are described in detail in the Background section of the report.

I. A   Authorship

This document is the result of a truly collaborative effort. While many individuals made it possible, it is important to acknowledge those who made key contributions.

The primary author is Abby Spector. Jessica Diamond ably assisted her in the writing of the document. Julie Norstrand and Abby Spector gathered and summarized most of the written material used in the report. The individual interviews with key informants were conducted by Abby Spector and Doris Rajagopal, Ph.D. Lisa Kleiner of Philadelphia Health Management Corporation supervised the consumer focus groups and wrote a summary of the findings, from which the quotes in this document were selected. Rachel Cohen, Christine Hoffman and Bethea Eichwald assisted in editing the document. LaTasha Johnson helped with the formatting of the final version of the report.

Two consultants played important parts in the creation of this document, Drs. Neal Cutler and Morton Kleban. Dr. Kleban played a vital role in the statistical analysis of data used in this report. Dr. Cutler helped shape the structure of this report and designed a set of questions that formed the base for our focus groups. More information on that process is to be found below.

The idea for this report came from the Board of Directors of Philadelphia Corporation for Aging (PCA). The specific goals, general outline, and overall supervision of the project was done by Allen Glicksman. David Nevison guided the project to its completion.

II. Summary of Significant Findings

Like most U.S. cities, Philadelphia is bracing itself for the coming demographic cohort of the aging postwar generation, born in the two decades after World War II (from 1946 to 1964). By the year 2035, this cohort will crest with a doubling of the U.S. population over 65. The leading edge of the postwar generation will reach the current retirement age of 65 by the year 2015.

The postwar generation of Philadelphia's future elderly is a heterogeneous group comprised only in small part of the stereotypical well-educated middle to high-income "baby boomer." Much of the current planning for the next generation of elderly is focused on these "boomers" as can be seen by the frequent use of the term by key informants interviewed for this project and the number of times that phrase appears in the title of documents and reports on the coming generation of older Americans. Philadelphia's urban environment brings an ethnically, racially and economically diverse group of elderly into close physical proximity and within the service areas of institutions and agencies that will be called upon to provide for the personal, social, economic and medical needs of these seniors.

Noteworthy trends and important statistics detailed in this report include:

- By the year 2015, Caucasians will no longer have majority status among the population of Philadelphians over the age of 60 – in part due to out-migration starting in the 1960s as well as in-migration by foreign born persons. Between now and 2015, the number of elderly Asian and Pacific Islanders combined will almost double (from 8,500 to 16,000 seniors). The number of Latino elderly will increase by almost 50%. The number of African American elders will rise by 12%; and the number of Caucasian elders will decline by 10%.

- By 2015 there will be a surge in the number of the region's frailest elderly, persons 85 and older, as well as among persons age 55 to 74. The 85+ group is expected to grow 10% between 2005 and 2015, and an additional 8% by 2025. The 55 to 64 year old group will grow 17% and the 65 to 74 year old group will grow 11% between 2005 and 2015. However, the 75 to 84 year old group will decline 22% during this same time frame.

- While Philadelphia's total population will decline between 2005 and 2015 from 1,468,000 to 1,411,000, the median age of a city resident will rise from 34 in 2000 to 36 in 2015.

- In 2003, Philadelphia ranked second only to Miami among 23 U.S. cities studied by the Brookings Institution in the proportion of residents age 65 and older. These 23 cities were participants in the "Living Cities" project, an urban revitalization program conducted by Brookings. They included 8 of the 10 largest U.S cities.

- In the Commonwealth of Pennsylvania, the number of persons age 60 and older is expected to grow by 37% - from 2.4 million in 2000 to 3.2 million in 2020.

Meanwhile, the US population over 65 is expected to increase 50% during that time frame, from 35 million to 54.6 million.

- Although an overall decline in disability among older adults is expected nationally in coming years, it may not occur in Philadelphia. This is possible because disability is known to occur at a higher rate among people living in poverty and Philadelphia is the seventh poorest city in the US.

- The proportion of elders living in poverty is higher in Philadelphia than in the state as a whole. In 2002, 19% of the city's seniors lived in poverty compared to 11% of seniors aged 65+ in Pennsylvania in the same year.

- The median income of seniors in the city is expected to rise by between 9% and 11% by 2009, but these figures have not been adjusted for inflation. As is now the case, the older age groups are expected to have lower incomes.

- National studies predict that the proportion of adults 65+ who are still working will grow from 13.3% in 2002 to 16.2% in 2015. Reasons for this trend include: decline or stagnation in pensions; uncertainty in the stock market; insufficient savings; cutbacks in health benefits for retirees; higher educational attainment and continued physical well-being, which correlates with later retirement; and smaller overall workforce. Whether these trends will hold for Philadelphia is uncertain.

- There are racial disparities in self-reported health among Philadelphia's elderly. As shown in the figure below, a greater percentage of both Caucasians and nonwhites have four chronic conditions in 2002 as compared to 1994. However, in each of the comparison years, nonwhites are affected more heavily than Caucasians. More widespread health difficulties indicate greater needs in the future.

Figure 1: Philadelphia Elderly with Chronic Health Conditions by Race: 1994 and 2002

Philadelphia Elderly with Chronic Health Conditions by Race: 1994 and 2002				
	Nonwhite		White	
	1994 (%)	2002 (%)	1994 (%)	2002 (%)
Allergies	25	31	23	27
Arthritis	50	57	44	50
Asthma	8	11	5	7
Diabetes	20	27	10	14

Source: PHMC

- Philadelphia's elderly population includes subgroups that are expected to grow by 2015 that are not currently fully recognized or adequately served, such as:
  - Seniors with chronic and late-onset mental illness and addictive disorders;
  - Elderly immigrants isolated by language and cultural barriers;
  - Seniors caring for their grandchildren;
  - Homeless seniors;

- o Elderly individuals with AIDS;

- o Developmentally disabled seniors;

- o Elderly ex-offenders;

- o Gay, lesbian, bisexual and transgender seniors;

- o Muslim, Buddhist and other religious populations.

- Because life expectancy for men and women is rising, more people will be married in old age. There will also be an increase in the number of persons entering old age who are single, divorced, separated or partnered. The proportion of persons living alone will probably remain stable. While partnered individuals will have the same affective and instrumental supports as married couples, issues of insurance and legal matters might be problematic.

- During the 1990's, Philadelphia saw an upsurge in the number of immigrants arriving in the city. In terms of all immigrants (including refugees and asylum-seekers) in the Philadelphia Metropolitan area in the years 1992-2001 - the three largest groups were from the former Soviet Union, India, and Vietnam. In 2001, the single largest source of immigrants to the region was India.

- Philadelphia's elderly population faces housing-related problems that include:

  - o Insufficient supply of subsidized housing units;

  - o Deteriorating housing stock and long wait lists for subsidized repairs;

  - o A shortage of affordable and accessible rental housing;

  - o Insufficient supply of handicapped-accessible housing;

  - o Problems with regulation and supply of personal care boarding homes;

  - o Elderly homeowners' vulnerability to predatory lending practices that lead to foreclosures.

- A trend that emerged from interviews with leaders in the field of aging is the far-reaching consequences of the shift toward community-based care – away from nursing home settings and away from mental health institutions. This shift has created new challenges for service providers in home care, transportation, housing, senior centers and adult day care, law and protective services as well as mental health and health care. It has also created new vulnerabilities for the elderly and/or their families who must assume responsibility for complex decision-making and management relating to health, mental health and other needs.

- Focus groups with consumers reveal many similar concerns. Participants worry most about finances as well as maintaining their health and coping with chronic illnesses as they age. They list their most critical needs as: affordable prescription medications, quality affordable home health care, affordable

adaptable housing, free or low-cost home repairs, assistance with utilities, information and support for caregivers and reliable Paratransit services. African American focus group participants, particularly those with less education, report the greatest challenges. They are more likely to experience chronic illness at a younger age, provide care for others, and lack financial resources.

Focus group members find it difficult to plan for the future because there are so many health and economic factors that are subject to change, and over which they have little control. Also, lack of information about community resources is an issue, particularly for consumers who are older, have less education and have never been caregivers. However, focus group members are certain of the value of preventive health measures as well as developing hobbies and leisure time activities that contribute to overall quality of life and well-being.

III. Background on Sources and Methods

The sources of information for this report include the following:

- Woods & Poole Economics, Inc., a well-regarded independent demographic and economic forecasting firm based in Washington, D.C. The firm provides national forecasts of demographic trends with county-by-county detail on projected changes, for instance in age, gender and race. The firm's data for the years 2005-2015 in Philadelphia provides the core of this report's key findings.

- The Philadelphia Health Management Corporation (PHMC) Southeastern Pennsylvania Household Health Survey which collects a wide range of information including basic demographics, physical and mental health, service use etc. The surveys were conducted between 1994 and 2002. Insights based on this data cannot be considered to be predictive.

- Integrated Public Use Microdata Series (IPUMS). This data set, maintained at the University of Minnesota, is a sample of individual level data drawn from U.S. Census files.

- Data from city, state and federal agencies, including the U.S. Census Bureau, is provided for context on trends identified by Woods & Poole.

- A review of relevant studies and programs from local, regional and national sources (see references in each section). For many topics, a variety of sources were used to obtain a sense of the general trend, both locally and nationally. Where several sources defined a trend, this report cites the most broadly applicable data source.

Two forms of data were provided by the Philadelphia Health Management Corporation: quantitative and qualitative. Many of the tables in the body of this report are based on the quantitative data collected by PHMC in their biennial survey, conducted on the telephone.

Respondents to the PHMC's survey include a random sampling of residents in five southeastern Pennsylvania counties: Philadelphia, Bucks, Chester, Delaware and Montgomery. In 1994, there were 2,845 respondents to the survey (of whom 1,171 lived in Philadelphia); 2,878 in 1996 (of whom 1,207 lived in Philadelphia); 2,834 in 1998 (of whom 1,076 lived in Philadelphia); 2,872 in 2000 (of whom 1,227 lived in Philadelphia) and 2,701 in 2002 (of whom 1,053 lived in Philadelphia).

The extensive telephone surveys were conducted with over 10,000 households, with an over sample of the population age 60 years and older. Topics include: self-reported health status and presence of health conditions, access and barriers to health care, use of health care services, satisfaction with care, personal health behaviors, limitations in functional ability, use of assistive devices, mental health, and respondents' demographic and socioeconomic status.

It should be noted that there may have been a selection bias against the older potential respondents with physical and mental health impairments in the PHMC telephone survey. For example, those with hearing loss or cognitive impairment might have been unable to complete the interview, and therefore are probably not well represented in the sample. The same is true for older persons who cannot complete a phone survey in English because they are foreign born.

The qualitative PHMC data appears as relevant quotes from elderly Philadelphians that begin many sections in this report. These quotes are drawn from transcripts of focus groups conducted by the Philadelphia Health Management Corporation (PHMC) in 2004 for this report. These authentic insights are intended to serve as a reminder to readers that the data in this report represent elderly individuals' unique emotions and needs. The volume of aging-related data is not intended to detract from their humanity and individuality.

> "...Until the day we die, whether at 102 or two, we want to be a person. That more than anything is the thing that really frightens me. It terrorizes me. That you become less and less a person. You are a case. You are a number. You are a thing. I don't worry about getting sick. I can always get well; and eventually I'll die. That's not a big choice. But it's what happens to me before I do. I don't look forward to being an IT." – Focus group participant

Consumer focus groups were conducted in May and June of 2004 by the PHMC for Philadelphia Corporation for Aging. PHMC conducted 12 focus groups, with members selected from subgroups of the population based on age (50-59, 60-69 and 70+), race (African American and white) and education (non-high school and high school graduates) or income. These groups were chosen because such subgroup differences often reflect variation in the need for and access to services. Respondents were asked to discuss: important factors in quality of life as people age; changing needs due to aging; caregiving concerns; perceptions of health and health care, finances, crime, and emotional and social well-being; aspects of retirement planning; plans for employment, housing, health and financial status in the future and services including financial, legal, employment, housing, social, mental health and health care. The value of focus group feedback lies in the specific insights of individuals. Hearing the authentic voices of individuals talking about their future needs in retirement may be as valuable for policymakers as the aggregated data.

The questions we asked were based on a series of questions designed by Drs. Neal A. Cutler and Nancy A. Whitelaw in their study, American Perceptions of Aging in the 21st Century (Cutler, 2002). This study, sponsored by the National Council on the Aging (NCOA), was a follow up to two previous studies to record changes in views about aging among older persons as well as younger adults. The study, conducted in the winter and spring of 2000, included questions about how the respondents (ages 18 and older) viewed the experiences of retirement and aging, what expectations people had, and what plans people were making for life in old age. The respondents were a nationally representative sample of 3,048 adults of whom 1,155 were 65 years of age or older. We decided that

these questions would be an excellent base on which to build our own set of questions for the focus groups, as the topics (what people saw in the future and what plans they were making) were the key topics for the report and the questions had already been tested in a close-ended form in a national survey.

We did look at the responses of the national sample and compare them to the responses we received from the focus groups. Of course any such comparison is very limited because the samples are so different in size, drawn from very different sources, and in one case the questions were asked in a close-ended format and in the other case in an open-ended format. The differences became apparent when we compared the demographics of the two samples (the published demographic data for the NCOA study is for persons 65 years and older). The focus group participants were poorer than the NCOA sample participants and fewer of the focus group members had living parents or living children than members of the NCOA sample. On the other hand, the NCOA sample showed a higher percentage of males and a higher percentage of males over the age of 70 than the focus group participants. Taken together this means that the national sample was overall higher socio-economic status than the focus group participants, which makes sense given the way the two samples were created.

In spite of these differences, there was much more agreement on the answers to the questions than one might expect. Both groups reported that their two main concerns in old age were financial issues first and health second. Both groups reported trying to do some planning for old age. The differences between the two samples became apparent here – the PHMC sample focused more on planning for leisure time, while the NCOA sample was more concerned about the management of funds saved for the purpose of retirement. Both groups reported trying to do things to prevent future health problems, including exercise, better nutrition, and seeing a physician on a regular basis. Among the PHMC sample there were no priorities among this group, while the NCOA sample put exercise and seeing a physician before changing eating habits.

The NCOA questions and the focus group responses influenced this report not only in giving us an idea of what persons in this age group are thinking, but by helping to determine the issues that became the focus of the final version of the document.

Additionally, most sections in this report close with a series of insights from community leaders on aging. These quotes are presented anonymously so that the substance of these insights can be shared and evaluated on their own merits – as free from political considerations as possible. While in some cases, data are not available to support the stated concerns, it is hoped that the issues raised will inspire a subsequent, more substantive analysis and increased civic attention.

In-depth interviews were conducted between April and October 2004 with 40 representatives of: city government, health and welfare departments; medical care providers; insurance companies; mental health service providers; legal service and advocacy organizations; housing experts; the Delaware Valley Regional Planning Commission; aging service providers including Philadelphia Corporation for Aging;

representatives of the lesbian, gay, bisexual and transgender community; and experts on issues facing aging prison, developmentally disabled, and homeless populations. Interviews were also conducted using several PCA Advisory Boards (Housing, Latino, and Asian) and the Hartford Center for Geriatric Nursing Excellence (HCGNE) at the University of Pennsylvania's School of Nursing. Although we have not listed all the individual members of these groups we are very grateful for the time they gave to meet with us and discuss these issues. A list of civic leaders on aging and the boards and other groups who were interviewed for this report is provided in the Appendix.

To place this report's trend forecasts into context, readers should keep in mind the following:

- The longer a projection is made into the future, the larger the percentage of error. Woods & Poole's national 10 year projection is estimated to have a 1.4% Average Absolute Percent Error (AAPE), compared to a 0.7% AAPE for its 1 year data projection. The AAPE is the simple mathematical average of the value of the difference between the projection and the actual value.

- Certainty of forecasts is reduced for smaller population groups, such as American Indians, because the predictive nature of the data is distorted by the small sample size.

- Similarly, due to smaller sample size, the Woods & Poole forecasts for small geographic regions are less accurate than national projections. This distortion is minimized by modifying U.S. Census data from 2000 with sophisticated modeling techniques that take into account specific local conditions using historical data from 1969 to 2001. Though not an indicator of future accuracy, the AAPE for Woods & Poole's 10 year total population projections has been +/- 10.2% for counties and +/- 5.1% for states.

- This document draws upon many different sources of data which may not always facilitate direct comparisons between local, state-wide or national trends. In these instances, the most reliable data available are presented as context rather than as a point of comparison. Some sources focus on slightly different age groups (different age ranges, for instance, or the 60+, 65+, 70+ populations, etc.). Other sources focus on different time periods with projections through 2010, 2015, 2020, 2025, 2030, etc.

- Additionally, at times, sources contradict one another. This report notes these differences where they are apparent. However, there may be other sources of data or analysis of which the authors were unaware.

- Projections in this report are based on an approach suggested by Dr. Neal Cutler of Widener University. Population projections are problematic because they are based on the flawed assumption that current trends will continue. While some trends identified in this report are stable, others are subject to unpredictable variables; for instance, no one could have predicted in the early 1990s that a wave of older immigrants would move to Philadelphia from the former Soviet Union. Dr. Cutler's technique is to use information from the health and socio-

demographic characteristics of the city's elderly to identify key risk factors for negative social and health outcomes among the elderly. These risk factors can be applied to projected population changes for the next ten years, allowing for adjustments of estimates of particular types of changes and risks if the aging population changes in unexpected ways.

- The future is, by definition, unknowable. Projections are based on interpolations of the known world that cannot fully take into account the possibility of unforeseen events in the future affecting the region's political, social or health status. While it is clearly impossible to develop an exact picture of Philadelphia's future population, there are trend lines that can be extended into the future in a reasonable way.

Sources:

Cutler, Neal E., and Nancy A. Whitelaw. AMERICAN PERCEPTIONS OF AGING IN THE 21st CENTURY [APA21], 2000 [Computer file]. ICPSR version. New York, NY: Louis Harris and Associates [producer], 2000. Ann arbor, MI; Inter-university Consortium for Political and Social Research [distributor], 2002.

IV. Philadelphia's Aging Population:
Anticipated Characteristics by 2015

IV. A   Population

IV. A. 1   Population Losses in Philadelphia – 1950-2015

> "I'm going to move because 50 years in my neighborhood and now it's getting so bad, I'm going to move. … My son's got an in-law suite in the back of his house that he's fixing. And I'm going to live with him and help them take care of his three children…." – Focus group participant

> "We have looked into moving because … the stairs are really bothering me, and my neighborhood has gone down, way down." – Focus group participant

An analysis of Philadelphia's future aging population should begin with historical context on the major demographic trends that have altered Philadelphia's demographic composition over the past few decades. Data from a variety of sources indicate that the accelerated population losses experienced by Philadelphia as a whole during the 1970s and 1980s slowed in the 1990s, but will continue to erode the community's population through 2015.

Figure 2: Philadelphia's Population 1970-2025
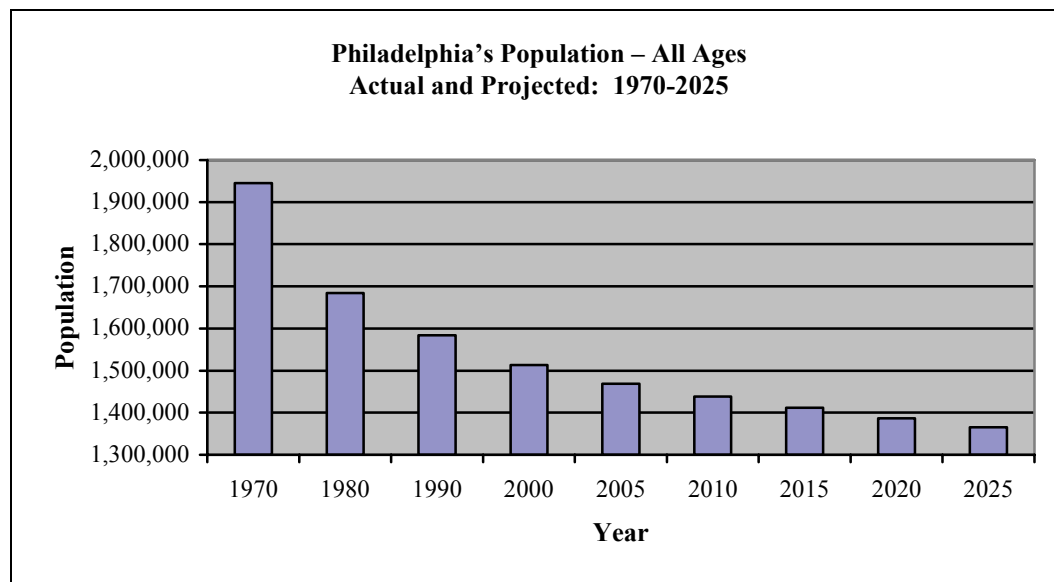
Source: Woods & Poole, 2004

In the 1950s, Philadelphia's total population peaked at 2 million people. (U.S. Geological Survey, 2000) The region's population has declined steadily ever since. These population losses undermine the tax base that supports the infrastructure serving

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the region's elderly population. The most dramatic decline occurred between 1970 and 1990 – a 20 year period marked by an 18% drop in Philadelphia's population (from 1.9 million in 1970 to 1.6 million in 1990). (Woods & Poole, 2004)

The region's rate of population decline slowed to 4.5% between 1990 and 2000. Woods & Poole estimates that Philadelphia's population declined from approximately 1.6 million to 1.5 million during that time period.

The population loss was not evenly distributed across income categories. During the period from 1979 to 1999, the proportion of high income households in Philadelphia (defined as more than $79,356 a year in 1999) dropped by 20%, while the proportion of low-income households (with annual incomes of $18,000 or less) rose by 15%. (Gorenstein, 2004) Among a sample of U.S. cities studied by the Brookings Institution, Philadelphia ranks seventh in the rate of poverty, almost 23% of adults of all ages and 17% of those ages 65+ had incomes below the poverty threshold. (Brookings, 2003)

Looking to the future, Woods & Poole projects that the Philadelphia total population will decline another 4% from 1,468,370 in 2005 to 1,411,250 in 2015 (representing a loss of 57,000 individuals) and on into 2025.

Population Losses in Philadelphia Section References

The Brookings Institution Center on Urban and Metropolitan Policy, 2003. *Philadelphia in Focus: A Profile from Census 2000*. Washington, DC: The Brookings Institution.

Gorenstein, N. *A Decline in the City's Well-to-Do Families*. Philadelphia Inquirer, August 11, 2004.

Saidel, J., Mandel, B., Babyak, K., Volpe, D., 1999. *Philadelphia: A New Urban Direction*. Philadelphia, PA: Saint Joseph's University Press.

U.S. Geological Survey, 2000. *Philadelphia Population Data*. Rolla, MO: Department of the Interior.

Woods & Poole Economics, Inc., 2004. *Demographic Data and Projections, 1970 to 2025, for Philadelphia*. Washington, DC: Woods & Poole Economics, Inc.

IV. A. 2   Anticipated Age-Related Trends

Looking more closely at historic changes among particular age segments, between 1970 and 2005, the number of Philadelphians age 55 and older declined steadily, down 27% from 1970 to the projected population for 2005. A similar change occurred among the 65+ group, which contracted 15% from 1970 to 2005 projections. (Woods & Poole, 2004) However, these aggregate numbers conceal a dramatic increase in the number of oldest old in the population.

Between 1970 and 2005, the younger segments (age 55 to 64 and 65 to 74) of the aging population declined 34% and 36%, respectively. However, the 75 to 84 group picked up 6%, and the 85+ group more than doubled in size. (Woods & Poole, 2004)

Figure 3: Historical Changes in Philadelphia's Aging Population

Historical Changes in Philadelphia's Aging Population: by Age Group, 1970 – 2005			
Age	1970	2005	% Change 1970-2005
55-64	210,180	138,960	-34
65-74	146,630	93,710	-36
75-84	67,150	71,150	6
85+	13,440	28,750	114

Source: Woods & Poole, 2004

At the same time that Philadelphia's total population is expected to decline between 2005 and 2015, the region will increasingly skew toward an older population, in part due to the looming presence of the postwar generation. The median age of a Philadelphia resident will rise from age 34.25 in 2000, to age 35.55 in 2015, and to age 36.38 in 2025. In 2003, Philadelphia ranked second only to Miami among 23 U.S. cities studied by the Brookings Institution in the proportion of residents age 65 and older. (Brookings, 2003)

Despite an overall 4% decline in Philadelphia's population between 2005 and 2015, and a 7% decline in the population under 55, the number of Philadelphia residents over 55 will grow 6% (by 20,000 people) during those years.

Extending this analysis over the 20 year period between 2005 and 2025, the city's overall population is expected to decline 7% (by 100,000 people), and the city's population under age 55 is expected to shrink 12% (by 140,000 people). Yet the 55+ group will grow 11% (by 36,000 people), and the 65+ population will increase 13% (25,000 people).

The most striking slice of anticipated demographic change will occur among the most vulnerable segment of the elderly – people who are 85 and older. The 85+ cohort is expected to grow 10% (from 28,750 to 31,630 individuals) between 2005 and 2015. Expanding the time horizon from 2005 to 2025, the growth of the 85+ cohort is projected at 19% (to 34,230 Philadelphians age 85+ by the year 2025).

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Figure 4: Population Changes in Philadelphia by Age Group, 2000 – 2025

Population Changes in Philadelphia by Age Group 2000 – 2025						
Age Group	**2000**	**2005**	**2015**	**2025**	**% Change 2005-2015**	**% Change 2015-2025**
Under 55	1,174,980	1,135,800	1,057,850	996,140	-6.9	-5.8
55 or older	338,480	332,570	353,420	368,800	6.3	4.4
60 or older	271,020	254,280	264,810	292,790	4.1	10.2
65 or older	213,120	193,610	190,640	218,870	-1.5	14.8
75 or older	106,710	99,900	86,740	97,290	-13.2	12.2
85 or older	27,446	28,752	31,632	34,226	10.0	8.2
Total	**1,513,460**	**1,468,370**	**1,411,270**	**1,364,940**	**-3.9**	**-3.3**

Source: Woods & Poole, 2004

The growing population of people over 85 merits careful planning and consideration by organizations providing services such as health care, social support, housing, and long-term care. People above age 85 are most at risk for chronic disabilities and are most likely to need long-term assistance from family, friends and outside agencies.

Another compelling trend for service providers will be the growth of the "young-old." Between 2005 and 2015, the 55 to 64 and 65 to 74 year old groups are expected to increase 17% and 11% respectively. The postwar generation falls right within these groups – they will range in age from 51 to 69 by 2015.

Organizations providing services to the elderly should take into account this increase in the "young-old." This population will still be relatively healthy and may be looking for retirement and financial planning assistance, social programs, health and mental health prevention, volunteer and employment opportunities, and caregiving and grandparenting support.

Figure 5: Philadelphia's Older Population by Ten-Year Age Segment, 2000-2025
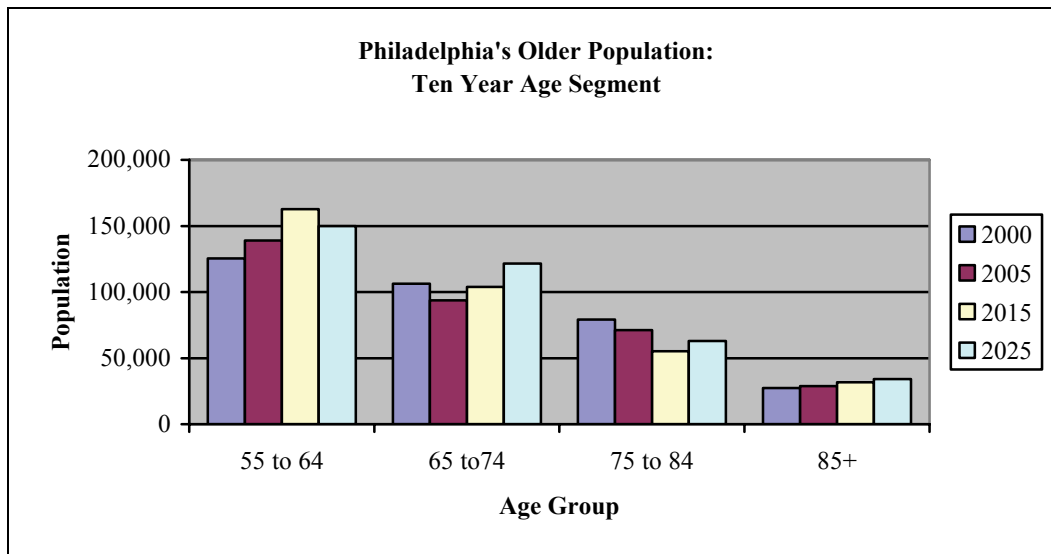
Source: Woods & Poole, 2004

Like the U.S. as a whole, the leading edge of the cohort of aging members of the postwar generation will begin to affect Philadelphia in just 10 years. However, this cohort will not reach full crest until 2030, when the entire postwar generation will be age 65 and older. Forecasting the future size of this looming demographic bulge should help health and human service agencies prepare to meet the needs of this generation as well as adjacent age cohorts.

To clarify the impact of the aging postwar generation progressively over time, in 2005 this cohort will be between the ages of 41 to 59 years old. In 2015, this generation will be 51 to 69 years old. By 2025, the entire postwar generation will be 61 to 79 years old.

To further explicate the dynamics of Philadelphia's aging population, this report includes a series of snapshots of the relative composition of Philadelphia's elderly age cohorts for 2005, 2015, and 2020.

Figure 6: Percentage of Philadelphia's 55+ Population

Percentage of Philadelphia's 55+ Population Accounted for by 10 Year Age Segments				
Age Segment	**2000 (%)**	**2005 (%)**	**2015 (%)**	**2025 (%)**
55-64	37	42	46	41
65-74	31	28	29	33
75-84	23	21	16	17
85 or older	8	9	9	9

Source: Woods & Poole, 2004

Snapshot: 2005
Among those 55 and older in 2005 (a total population of 332,000):

- 139,000 people or 42% are age 55-64 (up 11% from 2000 to 2005);

- 94,000 people or 28% are age 65-74 (down 12% from 2000 to 2005);

- 71,000 people or 21% are age 75-84 (down 10% from 2000 to 2005);

- 29,000 people or 8.6% are 85+ (up 4.7% from 2000 to 2005).

During this time frame, we see the leading edge of the postwar cohort entering the ranks of those between ages 55 and 64, a decline in the group ages 65 to 84, and an almost 5% increase in the very oldest and most vulnerable group.

Snapshot: 2015
Among those 55 and older in 2015 (a total population of 353,000):

- 162,000 people or 46% are age 55-64 (up 17% from 2005 to 2015);

- 104,000 people or 29% are age 65-74 (up 11% from 2005 to 2015);

- 55,000 people or 16% are age 75-84 (down 22% from 2005 to 2015);

- 31,000 people or 9% are age 85+ (up 10% from 2005 to 2015).

From 2005 to 2015, the aging of the postwar generation starts to become apparent. The 55 to 64 and 65 to 74 year old groups are expected to increase 17% and 11% respectively. The members of the postwar generation fall right within these groups – they range in age from 51 to 69 by 2015.

The 75 to 84 year old group is likely to drop 22%. A contributing factor may be migration from the city to the suburbs when this group was in its working years.

The 85+ group continues its steady increase, with a 10% rise from 2005 to 2015.

Snapshot: 2025
Among those 55 and older in 2025 (a total population of 369,000):

- 150,000 people or 41% are age 55-64 (down 8% from 2015 to 2025);

- 121,000 people or 33% are age 65-74 (up 17% from 2015 to 2025);

- 63,000 people or 17% are age 75 –84 (up 14% from 2015 to 2025);

- 34,000 people or 9% are age 85+ (up 8% from 2015 to 2025).

By 2025, the postwar generation will range in age from 61 to 80 years old, and as a whole they are likely to transform Philadelphia's demographics. If Woods & Poole's projected population changes occur, one in every four city residents will be age 55 or above. One in seven will be age 65+. And 2.5% will be age 85 or older.

Between 2015 to 2025, Philadelphia's 55 to 64 year old population is projected to slide 8% as the boomers age out of this group. During these years, the 65-74 year old group will grow 17%, and the 75 to 84 year old group will grow 14% as the boomers move into these age groups. The 85+ group will increase 8%.

National Projections

Philadelphia closely mirrors the nation in terms of the percentage of the total population that people 55+, 65+, 75+ and 85+ will represent in 2005, 2015 and 2025.

In 2005:
- People 55+ account for 23% of the total population in Philadelphia as well as nationally.

- Those 65+ comprise 13% of the city's population as well as nationally.

- Those 75+ comprise 7% of the city's population and 6.2% nationally.

- Those 85+ comprise 2% of Philadelphia's population and 1.7% nationally.

In 2015:
- People 55+ account for 25% of Philadelphia's residents, and 27% in the U.S.

- Those 65+ account for 13.5% of city residents, and 15% of the US population.

- Those 75+ account for 6 % of city residents, and 6.3% of the US population.
- Those 85+ comprise 2.2% of Philadelphia's population, and 2% of the U.S. population.

In 2025:
- People 55+ comprise 27% of Philadelphia's population and 30% nationally.
- Those 65+ comprise 16% of Philadelphia residents and 18% nationally.
- Those 75+ comprise 7% of Philadelphia residents and 8% nationally.
- Those 85+ comprise 2.5% of Philadelphia residents and 2.2% nationally.

Generally, the projected rates of growth for the 55 to 64 year old, 65 to 74 and 75 to 84 and 85 age groups are slower in Philadelphia than for the nation as a whole for the period from 2005 to 2015 and 2005 to 2025, although Philadelphia continues to have a slightly higher proportion of the old-old (85 and older) during those years. (U.S. Census, 2000)

Figure 7: Growth in Older Age Segments of US Population

Growth in Older Age Segments of US Population 2005-2025 (in thousands)					
Age Group	2005	2015	2025	% Change 2005-2015	% Change 2015-2025
55 to 64	29,690	39,919	40,125	34	1
65 to 75	18,461	26,307	35,603	42	35
75 to 84	12,943	13,256	19,598	2	48
85+	4,968	6,396	7,441	29	16

Source: U.S. Census, 2000

Figure 8: Growth in 65+ Population – Philadelphia, Pennsylvania and the US

Growth in 65+ Population Comparison: Philadelphia, Pennsylvania, and United States			
Area	% Change 2005-2015	% Change 2015-2025	% Change 2005-2025
Philadelphia	-1	15	13
Pennsylvania	12	27	42
U.S.	26	36	72

Source: Woods & Poole, 2004

Pennsylvania Projections

In Pennsylvania, the number of people ages 60 or older is expected grow 37% -- from 2.4 million in 2000 to 3.2 million in 2020. (Pennsylvania Department of Aging, 2004)

By the year 2020, Pennsylvania's 60 and older population is expected to be 25% of the total population – more than 3 million people. The 65 and older population is expected to

increase to 2.3 million, and the 85 and older population to about 363,000. (Pennsylvania Department of Aging, 2001)

From 2000 to 2010, the number of elderly ages 60 and older is projected to increase by about 9% to 2.6 million people. The number ages 60 to 74 will increase by about 15% to about 1.6 million.   The number ages 75 to 84 will decrease by 11% to 623,000 and the number of 85 and older will increase by more than 50% to 365,000. By 2020, it is estimated that those age 65 and older will constitute about 18% of the population. (Pennsylvania Department of Aging, 2001)

The size of Pennsylvania's population age 65 and over is expected to increase to 21% by 2025. Among the 50 states and District of Columbia, the state had the second highest proportion of elderly in 1995 and is projected to have the 16th highest in 2025. (Bureau of the Census, 1996)

Figure 9: Census Projections for Pennsylvania - Ages 65+

Census Projections for Pennsylvania Ages 65+	
Year	**Number of Persons**
2000	1,899,000
2005	1,867,000
2015	2,092,000
2025	2,659,000

Source: Bureau of the Census, undated

Insights from Community Leaders

Community leaders expect that shifts in the relative size of elderly age cohorts in Philadelphia will have wide-ranging implications that will be closely linked to the future political climate and level of activism among the elderly.

Broad Implications of Population Shift

"Philadelphia has a huge aging population compared to other cities. I imagine we will be on the forefront, leading the way for other cities on how to handle this transformation of our city's demographics."

"The great uncertainty about social services is how they will be viewed in the next ten years and beyond. Right now we are living in a war economy in which the aging are not a high priority even within the social services system. Compared to constituencies such as children and youth, preventative services, and major disease, the aging population is not a high priority. We're functioning with just basic bare bones programs, even though the system does a lot of good things. Are we going to continue in this subsistence mode or are we going to have an opportunity to reexamine what we are doing and possibly expand or retool?"

"I don't have an optimistic outlook because of the federal issues (the war and the deficit), the changing demographics and decreasing resources. Service providers for the aging face the challenge of managing limited resources in a climate of competing needs."

"The question that's the elephant in the room down the road is what will be the political dynamic and the value system. It could shift radically from what we know today to socialized medicine or something like that, or alternately the political climate could shift to a much more rugged individualism approach where everybody is out there on their own. It will be interesting to see where it all goes."

Post World War II Generation Impact

"Right now there is not a political outcry for an improvement in aging-related services. But the baby boomers are just on the cusp of being service recipients. It depends on how verbal they are going to be. Are they going to pick up on the lessons from the memories of the '60s and be active? I don't know. We are in very complacent times."

"The baby boom generation is a little less tolerant of inferior quality and barriers to service. They're a more educated consumer. But there is also a dynamic that they have difficulty accepting dependency. Over the last 20 years, dependency has gotten a bad reputation. At some point there is a shift where you are dependent but that shouldn't mean necessarily disempowerment."

"Baby boomers will want privacy, dignity and autonomy."

"There are people who are not yet 60 now who are used to the notion that they have a voice and should have a say in their living arrangements and everything else. As more of these people reach old age in the next 10 or 15 years, they are going to be more likely to speak up about the quality of services and expect more. As a result, we are going to need to be prepared to ensure that the services we're either directly providing or subcontracting need to be of better quality."

"What a lot of baby boomers say they want is choice – choice on how to live their life, and the freedom to do what they want to do, when they want to do it and how they want to do it. This has enormous implications. They have said, 'we are not going to have our parents' retirement.'"

"People who will be seniors in 2015 will be much more proactive, active consumers. They are the 60's generation who changed the nation. We expect them to have a clear set of expectations about a single point of access for health care. The people who built the unions and fought the civil rights struggles are very used to organizing. They know how it works."

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IV. A. 3   Future Ethnic Composition

General Population

Like many cities in the U.S., the trend toward the majority of elders being of minority status (when more than half of the combined population is non-white or Hispanic) in Philadelphia will intensify by 2015. Woods & Poole's data suggests that Philadelphia's minority populations will grow significantly between 2005 and 2015: by 38% among Asian and Pacific Islanders (32,720 more individuals), and by 21% among the Hispanic population (31,510 more individuals). These changes may be attributed in part to immigration from Asian and Latin American countries (see Immigration section of this report).

Meanwhile, Philadelphia's white population will decline by 18% (for a projected loss of 105,310 persons) between 2005 and 2015. A slight decline of 2% is forecasted in the number of the region's African American residents in that decade as well (a projected loss of 16,090 people).

Changes in each group's population will mean that the *proportion* of Philadelphia's white residents will drop from 40% of the city's total population in 2005 to 34% in 2015. As a point of reference, in 1990 whites accounted for 52.1 % of Philadelphia's residents, according to the Brookings Institution.

The *proportion* of African Americans in Philadelphia will remain stable – comprising 44.2% of the total population in 2005 and increasing slightly to 44.8% in 2015. At the same time, the growing Hispanic population will account for 12.6% of the city's residents by 2015, up from 10% in 2005. Asians will comprise 8.3% of the city's population in 2015, up from 6% in 2005.

Increase in the Number of Minority Elders

A shift also is occurring in the ethnic mix of Philadelphia's 60+ population. Between 2005 and 2015, the number of minority elders ages 60 or older will rise 21% (from 116,000 to 141,000), while the number of whites in that age group will decline 10% (from 138,000 to 124,000). During that ten year period, the number of:

- Asian and Pacific Islanders will almost double (from to 8,500 to 16,000 seniors).

- Hispanic elders will increase by more than 50% (from 10,000 to 16,000).

- African Americans seniors will rise 12% (from 96,000 to 108,000).

The rate of increase for minority seniors is even greater than the rate for the minority population of all ages.

The same changes are rippling through the 85+ group, those most likely to need formal services. From 2005 to 2015, the number of minority elders age 85 or older will rise 37%, while the number of whites will drop 3% (from 19,400 to 18,800).

Between 2005 and 2015, among individuals age 85+ the number of:

- Asian and Pacific Islanders will nearly triple (from about 500 to almost 1,500).

- Hispanics will increase 41% (from 510 to 710).

- African Americans will increase 27% (from 8,300 to 10,500).

Proportion of the Elderly Population by Ethnicity

In line with these trends, the proportion of Philadelphians ages 60+ who are white will decline from 54% to 46.8% between 2005 and 2015. By comparison, the proportion of:

- African American Philadelphia residents will increase from 38% of this age cohort to 41%.

- Hispanic Philadelphia residents will rise from 4% of this age cohort to 6% of this group.

- Asian and Pacific Islanders will comprise 3% of the 60+ population in 2005, rising to 6% of this population in 2015.

Similar changes will occur among Philadelphians age 85+. The proportion who are white will decline from 67.5% to 59.5% between 2005 and 2015. In contrast, the proportion of African Americans who are age 85+ will rise from 29% to 33%. Hispanic Philadelphians will increase slightly from 1.8% of this age cohort to 2.3%. And Asian and Pacific Islanders in the 85+ population will increase from 1.7% in 2005 to 4.6% in 2015. Due to small sample size, the projected numbers for American Indians reported below cannot be considered to be predictive.

These numbers suggest that more intense outreach efforts, along with culturally competent models of caring, will be critical to serve the increasingly diverse population.

Figure 10: Changing Ethnic Composition of the General Population (All Ages)

Changing Ethnic Composition of the General Population (All Ages)				
			Projected Change	
Ethnic Group	**2005**	**2015**	**Number**	**Percent**
White	583,500	478,190	-105,310	-18
Black	648,920	632,830	-16,090	-2
American Indian	3,730	3,790	0.06	+2
Asian/Pacific Islander	85,240	117,960	+32,720	+38
Hispanic	146,980	178,490	+31,510	+21

Source: Woods and Poole, 2004

Figure 11: Projected Changes in Ethnic Groups – Ages 60 and Over

Projected Changes in Ethnic Groups Ages 60 and Over				
			Projected Change	
Ethnic Group	2005	2015	Number	Percent
White	138,180	124,080	-14,100	-10
Black	96,181	108,018	+11,837	+12
American Indian	567	660	+93	+16
Asian/Pacific Islander	8,549	16,254	+7,705	+90
Hispanic	10,613	15,790	+5,177	+49

Source: Woods and Poole, 2004

Figure 12: Projected Changes in Ethnic Groups – Ages 85 and Over

Projected Changes in Ethnic Groups Ages 85 and Over				
			Projected Change	
Ethnic Group	2005	2015	Number	Percent
White	19,410	18,840	-570	-3
Black	8,285	10,526	+2,241	+27
American Indian	60	78	+18	+30
Asian/Pacific Islander	488	1,471	+983	+201
Hispanic	510	717	+207	+ 41

Source: Woods and Poole, 2004

Trends in Pennsylvania and Nationally

Statewide as well as nationally, the elderly population is becoming increasingly diverse. However, Philadelphia has a substantially greater percentage of non-white elders (age 65 or above) than either Pennsylvania or the U.S. as a whole. Non-white elders comprised 9% of Pennsylvania's population in 2000. This compares to a projection that non-white elders will comprise 60% of Philadelphia's ages 60+ population in 2005. From 1990 to 2000, the statewide number of Asian elders increased 115% and the number of Hispanic elders increased 42%. (Pennsylvania Department of Aging, 2001)

Nationally, in 2003, 17.2% of adults age 65 or older were non-white or Hispanic, including 8.1% African American, 2.7% Asian/Pacific Islander, 5.5% Hispanic, less than 1% American Indian and 0.5% identified with two or more races. (Administration on Aging, 2003)

Insights from Community Leaders

More information, outreach and customized services are needed to address the needs of minority elders who are isolated by their language or cultural background, according to community leaders who serve these populations.

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Unique Needs

"Minority elders are a potent force. They want to know how to connect with the aging system and have services better tailored for them. Minority elders have barriers to service that include language and culture; and they're usually poor. As this population grows, I have great concern about the ability of social service organizations to address their needs and their isolation. We are living in very conservative times with real pressures on our present financial social service structure."

"I think it behooves area organizations that service the aging and also the regular social services network to make better connections with community-based organizations for minority elders, such as mutual assistance organizations. Minority elders are much more comfortable dealing with someone from their culture as a point of entry for services."

"Ethnic senior citizens need to find a way to get their issues on the radar screen. They should create a forum in which they can explain what their problems are to providers and funding agencies. This would help them identify a collective way to address their needs. The present system lacks information about what these needs and issues are, and presupposes models that may not be relevant."

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IV. A. 4   Immigration

Future Projections

Another factor in the changing ethnic composition of Philadelphia is the unpredictable potential for an influx of immigrants from other countries in the next 10 years. After a period of declining immigration in the 1970s and 1980s, Philadelphia received a surge of newcomers of all ages in the 1990s. During that decade, the number of foreign-born residents grew 30% -- from 104,816 to 136,000 individuals. (Patusky and Ceffalio, 2004) Today, foreign-born residents comprise 9% of the city's population, while they account for 4% of Pennsylvania residents and 11% of the U.S. population. (Camarota, 2003 and Patusky and Ceffalio, 2004) These data are for all ages, not just the elderly population.

Although it is impossible to predict whether Philadelphia will receive a comparable number of immigrants between 2005 and 2015, the City's recent experience may continue. New immigrants commonly choose communities where others from their homeland have settled recently, and where it is easier to become part of the social and economic fabric. (Singer, 2004) According to the University of Pennsylvania's Fels Institute of Government, if Philadelphia's foreign-born population were to increase from 2000 to 2010 at the same rate as from 1990 to 2000, the city's foreign-born population would increase from 136,000 in 2000 to 177,000 individuals in 2010.

However, projecting immigration trends ten years out or farther is complex (and rarely done) because of the many uncertain variables involved. Whether or when a major social, political or catastrophic event in another part of the world will lead to immigration to Philadelphia cannot be predicted. As just one illustration, who would have anticipated that the Iron Curtain would fall in the 1980s, and that Philadelphia would become a major destination for immigrants from the former Soviet Union?

The largest groups of foreign-born now residing in Philadelphia are immigrants from the former Soviet Union, Vietnam, China, India and Jamaica. (Patusky and Ceffalio, 2004) In addition, there is a small, but growing percentage of Mexican and Central American immigrants in Philadelphia. These immigrants are likely to stay in this community as they age. As a result, they will influence the future ethnic composition of Philadelphia's elderly population.

Philadelphia's immigrant populations tend to cluster in five areas of the city (according to Fels):

- South Center City, where there is a mix of immigrants from China, India and other countries;

- South Philadelphia, with Vietnamese, Cambodian and Italian residents;

- Southwest Philadelphia, where there are sizable percentages of Vietnamese, African and Cambodian immigrants;

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- Far Northeast, with residents from Russia, Ukraine, India and other Eastern European countries; and

- Olney/Oxford Circle area, which has immigrants from a variety of countries, including India, Philippines, China, Vietnam and various Caribbean and South American countries.

Given patterns of resettlement, immigrants may be drawn to these neighborhoods as they arrive in the city.

Among Philadelphia residents age 60 years and older, approximately 13% were born outside the 50 United States. (IPUMS, 2000) Approximately 2.2% are from Puerto Rico (and therefore are American citizens), 2.4% are from the former Soviet Union, and 8.1% are from other countries. Among Philadelphia residents age 50 to 59, 4.5% are originally from Puerto Rico, double the percentage in the older age group. The percentage of 50 to 59 year olds coming from other countries is similar to the origin of those ages 60 and above. (Glicksman and Norstrand, 2004)

Most of the foreign-born elderly in Philadelphia came to the city when they were in their working years or younger. In fact, many have been in the United States for 21 years or more. Just 1% of those age 60 or older, and 2% of those 50 to 59, arrived in this country in the last five years. (Glicksman and Norstrand, 2004)

Relatively little detailed information is available about the size of the elderly population by country of origin, or about the specific needs of each group. However, five issues pertaining to elderly immigrants stand out.

- Linguistic isolation is a significant problem for the foreign-born elderly. Currently, 5% of immigrants age 60 or older identify themselves as linguistically isolated, meaning that they may speak English but not well or that they do not speak it at all. The problem is particularly acute among Spanish-speaking adults age 60 or older, 41% of whom report linguistic isolation. The same is true for 26% of Italian-speaking older adults. (Glicksman and Norstrand, 2004)

  Linguistic isolation is less pervasive among immigrants age 50 to 59, of whom 3.8% identify themselves as linguistically isolated. The problem is most serious for Spanish speakers in this age group, 19% of whom report linguistic isolation, and Russian speakers, 65% of whom report linguistic isolation. (Glicksman and Norstrand, 2004)

  Given the limited English skills of many new immigrants, and the increasing variety of languages, the health care and social service network will be challenged to continue to find ways to provide information and deliver services in the languages of the major immigrant groups. Diverse immigrant groups have diverse customs and cultures, and diverse views of and experiences with the health care and social service systems. There will be a continuing need for outreach programs

sensitive to these diverse linguistic and cultural backgrounds and for social services that are provided in a culturally competent context. (Singer, 2004)

- The Spanish speaking and Asian subgroups are themselves comprised of culturally and linguistically diverse groups. In the past, Philadelphia's Spanish-speaking population has primarily come from Puerto Rico; but in recent years, there has been an increase in the number of immigrants from other Latin American countries. The Asian community always has consisted of immigrants from many different countries, each with its own languages, cultures and historical experiences. (Glicksman and Norstrand, 2004)

- Linguistic minorities are not necessarily counted or identified as ethnic minorities. Immigrants from countries such as the former Soviet Union may appear ethnically Caucasian; but they are still linguistically and culturally isolated. These "non-minority" immigrants need to be better understood, especially since a third wave of migration from that part of the world is underway. (Glicksman and Norstrand, 2004)

- New immigrants are likely to need income support and assistance with benefits eligibility. Poverty is a reality for many immigrants. Poverty levels for the foreign-born tend to outstrip those of people born in the U.S. Immigrant households tend to have greater welfare use and more uninsured individuals. (Camarota, 2003) Issues of citizenship and eligibility for a variety of public benefits are likely to become more of an issue for the Latino community as more immigrants come from countries other than Puerto Rico (migrants from Puerto Rico are eligible for U.S. government benefits due to their status as citizens).

- The recent surge of immigration to Philadelphia means enriched cultural diversity for the City. It also means fresh entrants to the workforce who may seek jobs in eldercare, an area where the needs already are pressing and will continue to be for at least the next 30 years. Some new immigrants are highly skilled medical professionals, while others are unskilled but may be attracted to entry-level work in the health care and social service fields.

  For the eldercare field and other potential employers of immigrants to be able to capitalize on the presence of new workers, there will be a need to provide new immigrants with general education as well as training in job-related skills and English language competency. (Singer, 2004)

Figure 13: Immigrants, Refugees, and Asylum-Seekers in the Philadelphia Metropolitan Statistical Area

Number of Immigrants, Refugees, and Asylum-Seekers in the Philadelphia Metropolitan Statistical Area from 1992 – 2001		
	1992 - 2001	**2001**
Soviet Union, Russia & Ukraine	24,838	1,791
India	11,796	2,012
Vietnam	11,161	885
China & Hong Kong	9,913	1,262
Korea	4,409	583
Mexico	4,174	658
Philippines	4,150	409
Jamaica	3,786	334
UK	3,437	356
Poland	2,839	198
Dominican Republic	2,226	231
Haiti	2,020	181
Pakistan	1,950	277
Canada	1,898	300
Total	**130,683**	**14,796**

Source: Patusky and Ceffalio, 2004

[1] The Philadelphia MSA includes Philadelphia, Bucks, Chester, Delaware and Montgomery counties in Pennsylvania; Burlington, Camden, Gloucester and Salem counties in New Jersey; New Castle county in Delaware and Cecil county in Maryland.

The data in the table above (taken from the Fels report) show that during the composite period from 1992 to 2001, the Soviet Union (with Russia and Ukraine) was the largest single source of immigrants to the Philadelphia Metropolitan Statistical Area followed by India, Vietnam, and China (with Hong Kong). In 2001, India topped the list, followed by Ukraine combined with the Soviet Union and Russia, China (including Hong Kong) and Vietnam.

Insights from Community Leaders

Senior service providers face unique challenges associated with their efforts to serve elderly immigrants, according to community leaders. They point to creative ways, both formal and informal, to address this diverse population's needs.

Overcoming Language and Cultural Barriers

"Organizations need to hire as diverse a staff as possible, but diversity doesn't inherently mean better. People need to have a basic understanding of the human need for courtesy and respect, the need to sit down and explain services."

"Many agencies still are not providing adequate language access. Growing immigrant groups such as the huge Russian, Latino and Asian populations have increasing issues relating to social access."

"A lot of companies say 'we want diversity taught to our staff,' and they do it. The staff may learn it, but top management doesn't get it. I think senior management should attend a lot of these diversity training sessions."

"Health literacy should be addressed for different languages and cultures so that they can take charge in a doctor's office versus feeling totally overwhelmed."

"Many immigrants don't know that there are services available to support older adults such as home health care. Or they feel reluctant to place their parents in nursing homes. Ten years from now that thinking is going to change. They are going to start reaching out for help. As organizations meet federal regulations for culturally and linguistically appropriate language and translations in their literature, immigrant communities will begin to use those services more and more often."

"Physicians need to be more culturally competent. Providers need to tailor services to non-English speaking populations. As culturally distinct immigrant populations age, we need to understand, interpret and respect their folk medicine and integrate that into how we care for them. To work with the Latino, Chinese, or Cambodian communities, for instance, you need to see that there are some commonalities, but there are also issues that are really different. There are a lot of challenges around language and culture, and we need to put a lot more energy into training people who go into aging to work with people from different cultures."

"There are not enough social workers who speak Spanish or Asian languages. While serving Hispanic elders is somewhat easier because they come from many countries but speak one language, Asians have many different languages and distinct ethnic groups. We can't hire people who speak every language spoken by our elderly clients, but we do try."

"The Asian community is really growing and has significant needs and language barrier issues. You can't serve that population without an interpreter. We're seeing growing numbers of Chinese, Cambodian and Vietnamese elders. The Indonesian population has grown in the last few years, as well."

"When you can't have a professionally trained bilingual staff, it's useful to have people who have some understanding of the culture and the language. Even having bilingual volunteers would be very useful."

"One effective way to reach out and educate people from different cultures is to find younger people who speak the language, who understand the culture, and who are credible sources of knowledge and information to educate the immigrant population, dispel myths, and get them access to services."

"We should look at Oregon's demonstration programs for "cash and counsel' through which they allow consumers to choose and hire their own personal care aides. Often

they're individuals from the same culture who speak the same language as the consumer."

"We will have professionals in the aging network who are able to deal with the diversity, who are bilingual, bicultural and multi-cultural. But the real challenge will be whether the system that will be in place will be friendly to people of diverse cultures and backgrounds."

"We need to develop a more diverse mental health professional pool – especially one that offers language diversity and cultural competence. How many Cambodian or African licensed clinical social workers do we have? How do we attract more people from these populations to obtain this training? This is a double-edged sword: to the extent that diverse elders are impoverished, there won't be funds to pay for mental health services. Until every person, whatever the income, has decent mental health and health insurance through which providers can be paid, only then can you encourage ethnic young people to enter these professions."

"If you tour our health care system, it serves people from all continents, all demographic groups and cultures. Overcoming cultural and language barriers is one of the greatest challenges we face for our health care system – particularly in the Asian population which has really increased in Philadelphia and which includes a number of very diverse groups."

"In one program serving an older Korean population, having Korean workers through Title V who were bilingual helped draw in the Korean population. That encouraged older Korean people in the community to come to the center for assistance."

"Technology is going to help. For instance, our organization has one telephone line that is dedicated just to the Korean community. The phone is answered in Korean electronically, and each call is distributed to a Korean-speaking person who can handle callers' particular problems or questions."

"Our company is putting together a computerized language system that's programmed for emergency rooms where people will go in, see a video in their language of what to expect, what kinds of forms they have to fill out, and also that explains that the information patients share will be kept confidential. This program will be set up to translate information back and forth electronically both ways between the patient and the care provider. We hope eventually that this computerized language system could be used for assessments where our staff members would go into the community and get information from clients even when they don't speak the same language."

"Even our food service should reflect a respect for the diversity of our elderly clients. We need to expand our meal options. We have kosher meals, but we also need Halal, Latino, Laotian, Vietnamese and Thai meals. That's a real challenge in terms of budgets and capacity but it's an important goal."

Immigrants' Unique Needs

"Senior centers need more English as a second language classes for adults that are not just limited to the over 60 population."

"Some immigrants' families follow a pattern in which the children moved away for their careers but weren't able to take their parents with them. Those parents are left isolated and need other types of caregiving arrangements. Maybe we will have to have some kind of housing arrangements for them or centers or groups where they would feel less isolated and have someone to take the place of the caregiver."

"Immigrants don't have the income, and may not even have the health benefits of the public health system that we have had in the U.S. They are poorer, not as healthy, and have a language barrier. These are all barriers to healthy aging."

New Populations

"I'm seeing for the first time a lot of older people who are immigrants from communities that are having a presence in Philadelphia for the first time. These are people who don't use the systems and are under the radar of demographers and official head counters such as the U.S. Census. I see a lot of Arab elders in the city. Ten years ago, I rarely saw any. There are a lot more Dominicans, older Columbians and elderly people from other places in South America coming here to retire."

"Philadelphia has not captured its share of foreign immigration relative to lots of other major cities. This, in part, is what's driving or is responsible for the population loss in the city. However, in the future, immigrants even at the modest levels coming to Philadelphia today will become a higher percentage of Philadelphia's population – particularly due to the forecasted Caucasian out-migration."

"We have to adjust and respond to the continually changing demographics. We try to anticipate where will our future immigrants come from. We are looking forward to another influx of Muslims coming in. A lot of people don't understand the cultural thinking of the Muslim community, and we need to."

Immigration Section References

Camarota, S., 2003. *Immigration in a Time of Recession: An Examination of Trends Since 2000.* Washington, DC: Center for Immigration Studies.

Glicksman, A. and Norstrand, J., 2004. *The Socio-Economic and Health Characteristics of Philadelphia's Elderly Population.* Philadelphia, PA: Philadelphia Corporation for Aging.

Patusky, C. and Ceffalio, J., 2004. *Recent Trends in Immigration to Philadelphia, Pennsylvania: Who Came and Where Do They Live?".* Philadelphia, PA: University of Pennsylvania Fels Institute of Government.

Singer, Audrey, 2004. *The Rise of New Immigrant Gateways.* Washington, DC: The Brookings Institution.

IV. A. 5   Gender

The projected future ratio of women to men in Philadelphia is weighted more strongly toward women than comparable projections nationally. This is true for each of the four age groups profiled (55+, 65+, 75+ and 85+), both in 2005 and in 2015.

Although men are living longer (Social Security Administration, 1995; Siegel, 1996), this gender imbalance continues in nearly unchanged proportions in projected data for 2005 and 2015.   With each successively older age cohort, the Woods and Poole projections indicate that there will be increasingly more women than men. Though the gender gap has narrowed somewhat, it is still a significant factor. This trend among Philadelphia's future elderly population may be a meaningful indicator for service providers.

- For individuals ages 55+ in 2005, the projected ratio in Philadelphia (60% women to 40% men) is more unbalanced than national projections for the same year from the U.S. Census Bureau (55% women to 45% men). By the year 2015, the Philadelphia ratio (59% women to 41% men) changes only slightly compared to U.S. Census data (54% women to 46% men).

- Gender disparity is more marked in the 65+ population. For individuals age 65+, the projected ratio in Philadelphia (62% women to 38% men) is expected to remain unchanged between 2005 and 2015. Nationally, this disproportion closes slightly from 2005 (58% women to 42% men) to 2015 (57% women to 43% men).

- Gender disparity increases again in the 75+ population. The projected ratio in Philadelphia for persons 75+ in 2005 (66% women to 34% men) shifts slightly to 67% women and 33% men in 2015. Nationally, this disproportion is less pronounced. In 2005, a population composed of 61% women and 39% men is expected, compared to 60% women and 40% men in 2015.

- Disparities between Philadelphia and national projections widen further for the 85+ population. For individuals age 85+ the projected disproportionate ratio in Philadelphia (72% women to 28% men) in 2005 will grow slightly by 2015 (73% women to 27% men). Nationally this disproportionate ratio in 2005 (68% women to 32% men) is expected to shrink slightly by 2015 (66% women to 34% men).

Anticipated Population of Men and Women by Age Cohort - Philadelphia

Figure 14: Projection for Male Senior Population by Age Segment

Projection for Male Senior Population by Age Segment					
Total Males	**2000**	**2005**	**2010**	**2015**	**% Change (2000-2015)**
55-64 Years	55,510	61,560	68,770	73,840	33
65-74 Years	44,070	38,810	39,160	43,380	-2
75-84 Years	28,230	25,920	22,130	20,180	-29
85 Years and Older	7,290	7,910	8,480	8,590	18
Total Men - 55 and Older	**135,100**	**134,200**	**138,540**	**145,990**	**8**

Source: Woods & Poole, 2004

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Figure 15: Projection for Female Senior Population by Age Segment

Projection for Female Senior Population by Age Segment					
Total Females	**2000**	**2005**	**2010**	**2015**	**% Change (2000-2015)**
55-64 Years	69,850	77,400	84,600	88,920	27
65 to 74 Years	62,340	54,910	55,090	60,530	-3
75-84 Years	51,030	45,230	38,760	34,920	-32
85 Years and Older	20,150	20,840	22,010	23,040	14
Total Women – 55 and Older	**203,370**	**198,380**	**200,460**	**207,410**	**2**

Source: Woods & Poole, 2004

Gender Section References

Siegel, J., 1996. *Aging into the 21st Century.* Washington, DC: U.S. Department of Health and Human Services, Administration on Aging.

U.S. Bureau of the Census, Population Division, undated. *Projections of the Population, By Age and Sex, of States: 1995 to 2025*. Washington, DC: U.S. Bureau of the Census, Population Division, Population Paper Listings #47.

U.S. Department of Health and Human Services, Social Security Administration . Selected Demographic Assumptions by Alternate Calendar Years 1940 – 2070. Washington, D.C.: Social Security Administration.

Woods & Poole Economics, Inc., 2004. *Demographic Data and Projections, 1970 to 2025, for Philadelphia*. Washington, DC: Woods & Poole Economics, Inc.

IV. A. 6   Marital Status

Marital status of elderly men and women is another meaningful determinant of the need for long-term care services. When one member of a couple is ill or disabled, his or her spouse can be an important source of assistance, minimizing the need for outside help. The opposite is true, as well: older people who live alone and have no children or relatives are more likely to need formal care. (Stone, 2000) Since the life expectancy advantage of women over men has been slowly and steadily decreasing, it is anticipated that women will be widowed somewhat later in their lives. It should be noted that the life expectancy tables project that by 2010, the difference in male and female life expectancies will stabilize at 6.2 years, until 2035.

National Projections

The Administration on Aging report, "Aging into the 21st Century," forecasts national trends in marital status for the elderly through 2010 using data from the U.S. Census Bureau and the Social Security Administration. This analysis shows that in the year 2000 significantly fewer women age 65+ than men age 65+ were married and living with a spouse. This trend is expected to continue through 2010, and is more exaggerated among successively older populations.

An Administration on Aging report cites the following marriage data for 2000 to 2010 (Siegel, 1996):

- Among individuals age 65+ in the year 2000, men were significantly more likely than women to be married with a spouse present (71% compared to 37%). This disproportion in marital and living arrangements among individuals 65+ is expected to continue at least until 2010 (71% men compared to 39%). Note that a slightly higher number of women will be married in 2010 as compared to 2000.

- Among individuals age 75+ in the year 2000, again men were much more likely than women to be married with a spouse present (64% compared to 22%). Projections for 2010 show a continuation of this trend in marital and living arrangements (66% men compared to 24%).

- Among individuals age 85+, comparing data for the year 2000 to projections for 2010, the percentage of men and women who were married declined further, reflecting a higher incidence of widowhood among this age group. Again, men were more likely than women to be married with a spouse present in 2000 (53% compared to 12%), a trend that continues virtually unchanged in 2010 when 55% of men are expected to be married , compared to 13% of women.

Figure 16: Percent Married with Spouse - 2000 & 2010 Projection

Percent Married with Spouse 2000 & 2010 Projection National Data by Age & Gender		
Gender and Age	**2000 (%)**	**2010 (%)**
Male		
65+	71	71
75+	64	66
85+	53	55
Female		
65+	37	39
75+	22	24
85+	12	13

Source: For 65+ and 75+ groups, based on Census Bureau projections cited in Siegel, 1996; for 85+ group, based on Social Security Administration projections cited in Siegel, 1996

Although most studies seem to agree on the general trends, it should be noted that projections for marital status vary based on the assumptions and definitions that are applied in each analysis. For example, Social Security Administration projections classify people who are married but not living with their spouses as "married," whereas the Census Bureau data distinguish those who are "married, spouse present" from those where the spouse is absent. Census Bureau data are used here as a more meaningful indicator of financial, emotional and logistical support within elderly households. The Social Security Administration's more inclusive definition tends to yield projected percentages that are slightly higher than those from the Census Bureau.

A study by the AARP Public Policy Institute projects marital status specifically among men and women age 75+ from 2000 to 2020. The study shows a gradual increase in the proportion of women who are married over the next 15 years, and a constant marital rate among men. The proportion expected to face widowhood in the AARP study drops significantly over time for both groups, with an even more dramatic decline for women than men. (Redfoot and Pandya, 2002)

- The proportion of men age 75+ who are married is expected to remain stable at 66% between 2000 and 2020. Marital rates among women are expected to rise slightly from 2000 to 2020 (from 26% to 29%).

- Widowhood experienced by men age 75+ is expected to decline between 2000 and 2020 (dropping from 25% to 23%). Similarly, among women age 75+ the proportion expected to face widowhood is expected to decline from 2000 to 2020 (dropping from 65% to 57%).

- Divorce rates among men age 75+ are expected to rise between 2000 and 2020 (from 4% to 7%). Divorce among women age 75+ is expected to increase during that period as well (from 4% to 10%).

- Only slight declines occur among the projections for individuals who will be single, when comparing 2000 data to 2020 projections. There is expected to be only a 1% decline among men and a 2% decline among women in the number of individuals expected to be single in 2020.

Figure 17: Percent in Marital Status for Persons 75+ Nationally

Percent in Marital Status for Persons 75+ Nationally 2000 to 2020 (Projection) by Gender				
Gender and Year	**Married (%)**	**Widowed (%)**	**Divorced (%)**	**Single (%)**
Men				
2000	66.1	25.0	4.4	4.5
2010	65.4	24.5	5.9	4.2
2020	66.4	22.8	6.9	3.9
Women				
2000	25.6	64.8	4.0	5.6
2010	26.5	62.5	6.4	4.5
2020	28.8	57.0	10.0	4.2

Source: Redfoot and Pandya, 2002

Philadelphia Projections

Census data for the year 2000 in Philadelphia for older men and women combined (age 65+) show:

Figure 18: Marital Status of Older Men and Women in Philadelphia, Ages 60+
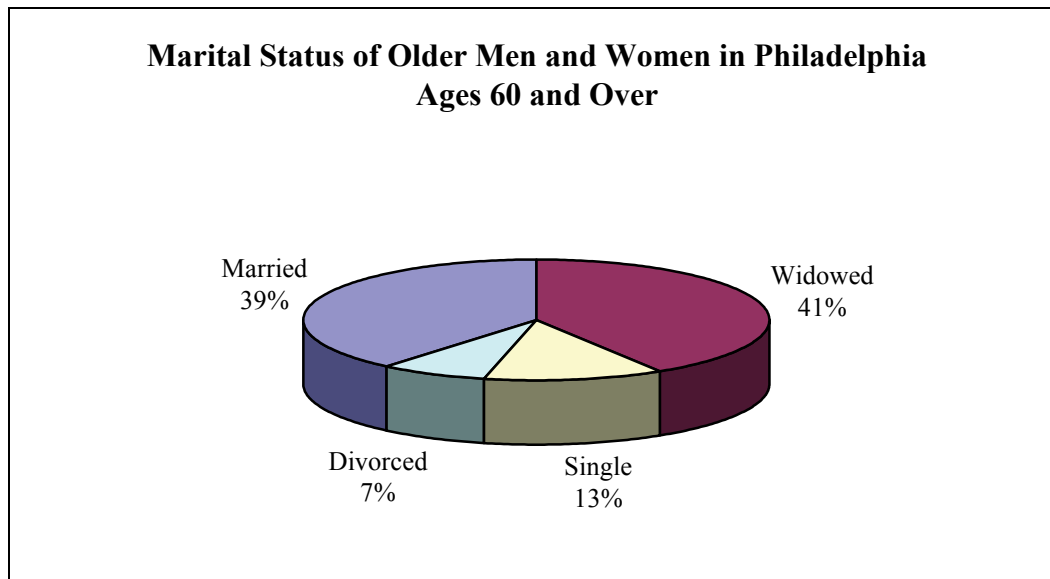
Source: U.S. Census, 2000

In keeping with national figures, twice as many Philadelphia females are widowed (50%) as males (22%). Similarly mirroring national trends, the proportion who are widowed increases with age. Over half (61%) of those who are age 85 or older are widowed.

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Almost half (44%) of Caucasian seniors in Philadelphia are married, while 30% of older African Americans are married. African Americans are more likely to be divorced (9%) than whites (5%), and more likely to be widowed (African Americans, 45%; Caucasians, 38%).

Looking to the future, the current cohort age 50 to 59 has a higher rate of divorce (16%) and separation (8%) than those ages 60+ (9% divorced and 4% separated) – trends that can be expected to continue in the coming decades. (Glicksman and Norstrand, 2004)

Marital Status Section References

Glicksman, A. and Norstrand, J., 2004. *The Socio-Economic and Health Characteristics of Philadelphia's Elderly Population*. Philadelphia, PA: Philadelphia Corporation for Aging.

Redfoot, D. and Pandya, S., 2002. *Before the Boom: Trends in Long-Term Supportive Services for Older Americans with Disabilities*. Washington, DC: AARP.

Siegel, J., 1996. *Aging into the 21st Century*. Washington, DC: U.S. Department of Health and Human Services Administration on Aging.

Stone, R., 2000. *Long-Term Care for the Elderly with Disabilities: Current Policy, Emerging Trends and Implications for the Twenty-First Century*. New York: Milbank Fund.

IV. A. 7   Living Arrangements

National Projections

Nationally, approximately three-fourths of men age 65 or older, and one-third of women, are married and living with their spouses. Among the approximately one-third of all older people who are living alone, the vast majority (80%) are women. According to the Administration on Aging, one in eight elderly individuals live with other relatives, not including a husband or wife.

A study by Lewin/ICF cited in the Administration on Aging Report, "Aging into the 21st Century," projects that a constant proportion of older people will live alone between 1990 and 2020 (see table below). However, the report notes that increases could occur if upcoming cohorts of elders have the good health and financial resources to accommodate living alone. (Siegel, 1996)

The likelihood of living alone increases with age. Close to one-half (45%) of those age 85+ currently live alone, and the same percentage is projected for 2020. Hispanics are less likely than others to live alone in old age now and in the future. (Siegel, 1996)

Figure 19: Persons Age 65+ Living Alone 1990 to 2020 (Projected)

Persons Age 65+ Living Alone 1990 to 2020 (Projected) by Sex, Age, and Race (In Thousands)						
	1990		**2005**		**2020**	
Age, Sex, Race	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Total	9,176	31	10,934	32	15,220	31
Sex						
Male	1,943	16	2,437	17	3,604	17
Female	7,233	42	8,497	43	11,616	42
Age						
65-74	4,350	24	4,542	25	7,679	25
75-84	3,774	40	4,534	38	5,210	38
85+	1,051	47	1,857	45	2,331	45
Race						
White	8,027	31	9,087	33	11,910	31
Hispanic	226	22	482	24	930	25
Black and Others	925	30	1,365	31	2,381	32

Source: 1990 data-U.S. Bureau of the Census (1991). Projections-Lewin/ICF (1990) estimates based on data from the Current Population Survey and the Brookings/ICF Long Term Care Financing Model. Cited in "Aging into the 21st Century."

Note: Percentages represent the number living alone out of the total population in the class shown. The groups – White, Hispanic, and Black and Others – are defined as three mutually exclusive categories. Numbers were rounded. This accounts for the occasional discrepancies from the total.

Current Local Data

In Philadelphia, more than one-third of older people (age 65+) live alone (36%), somewhat higher than the percentage projected for 2005 nationally (32%). Forty-one percent live with one other person, and 23% live with two or more other people. Among those experiencing widowhood (both men and women), 62% live alone, and 38% live with one or more other people. (Glicksman and Norstrand, 2004)

Living Arrangements Section References

Glicksman, A. and Norstrand, J., 2004., *The Socio-Economic and Health Characteristics of Philadelphia's Elderly Population*. Philadelphia, PA: Philadelphia Corporation for Aging.

Siegel, J., 1996. *Aging into the 21st Century*. Washington, DC: U.S. Department of Health and Human Services Administration on Aging

IV. A. 8   Education

Locally, as well as nationally, seniors in 2015 are likely to be better educated than they are today. More highly educated seniors are likely to be savvier consumers of health care and social services. They may be more aware of their options, rights and entitlements; and they may respond to new modes of information and outreach, including the Internet.

In Philadelphia in 2002, distinct differences in educational attainment appeared when comparing individuals who were ages 60+ with individuals who were age 50 to 59 that year. Among those age 50 to 59, 40% attended one or more years of college, whereas only 23% of the 60 and up age cohort had at least some college. Eighteen percent of the age 50 to 59 cohort completed four or more years of college, while just 10% of those age 60 and up attended four or more years of college.

Similarly, 61% of individuals age 50 to 59 terminated their education with 12 or fewer years in school, as compared to 78% of individuals age 60 and up.

Figure 20: Highest Level of Education Completed

Highest Level of Education Completed: Philadelphia 2002
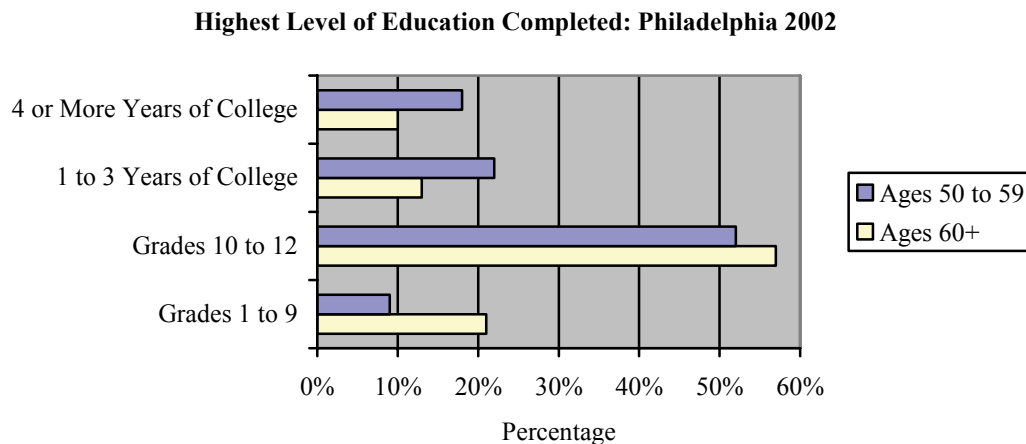
Source: PHMC, 2002

Nationally, the number of older people who have completed high school and college has been on the rise. In 1997, just 66% of older people had completed high school, but the percentage is expected to rise to 75% by 2010 and to 88% by 2020. Meanwhile, the percentage of seniors with a college degree or higher is expected to more than double between 1990 and 2020 – from 11% to 24%. (Shapiro, 1997)

It is important to note, however, that improvements in educational attainment may not continue at an even pace. For example, the Urban Institute predicts an improvement in educational levels among the elderly from 1993 to 2012 but then some erosion after that. (Toder, 2002) Among those retiring in 2010, 32% are likely to be college graduates, yet only 27% of those retiring after 2013 are expected to have a college degree. The Urban Institute (Butrica & Uccello, 2004) anticipates that traditional differences in education by

gender will virtually disappear among late postwar generation retirees (those born between 1956 and 1965 and who will be age 50 to 59 in 2015). Improvements in educational levels among the elderly will lag among African Americans and Hispanics. (Stone, 2000)

Internet Use among Seniors

Two recent telephone surveys have compared Internet use among adults age 65+ with adults age 50 to 64. Results from both studies suggest that online resources are likely to play a more significant role for older people, particularly the affluent and well-educated. Over time, the Internet may become a salient source of information for seniors about aging-related issues, services and entitlements. It may also provide a connection to help isolated, homebound seniors keep in touch with family and friends. (Kaiser, 2005)

The Pew Internet and American Life Project (Fox 2004) found that 22% of people age 65 and over nationally use the Internet. This represents a 47% jump in Internet usage between 2000 and 2004. A Kaiser Family Foundation (2005) study found that a slightly higher proportion, 31%, of people age 65 to 74 had ever gone online.

Both studies found that a substantially higher percentages of people age 50 to 64 – 58% - use the Internet. This group will be between the ages of 60 and 75 by 2015. In the Kaiser study, 70% of those ages 50 to 64 had gone online. The study also found that online resources for health information may soon play a larger role among older Americans. Twenty-one percent of seniors had gone online to look for health information compared to 53% of 50 to 64 year olds.

Although the rate of Internet use is on the rise, there is a "substantial digital divide" (Kaiser 2005) among seniors based on socio-demographic factors. The Pew study found that Internet use occurred mainly among better educated, higher income seniors . Sixty-two percent of "wired" seniors had at least some college, compared to 35% of all Americans 65 or older. Seventeen percent of "wired seniors" live in high income households ($75,000 per year or more) compared to just 4% of all seniors (although 39% of all seniors refused to divulge their income). Just 11% of African Americans age 65 and above reported using the Internet in 2003, compared to 22% of whites and 21% of Hispanics in the same age category.

Similarly, a study by the Kaiser Family Foundation (2005) found that seniors with an annual household income under $20,000 were much less likely to have gone online (15%) than those with incomes between $20,000 and $49,000 (40%) or those with incomes of $50,000 a year or more (65%). Similarly, seniors with a high school diploma or less (18%) were much less likely to have gone online than those with some college (45%) or a college degree (60%).

While Internet use is likely to increase in Philadelphia, the emerging demographic and economic profile of the city's older population may be a limiting factor.

Insights from Community Leaders

Continuing education for seniors is a valuable component of healthy aging, according to community leaders who also point to more specific educational needs such as literacy training and computer skills. Competence in these areas helps seniors navigate life decisions.

Continuing Education Needed

"Senior centers shouldn't just be for old, retired people to sit and chat. They need to be learning places that provide continuing education and health support – where people can go and learn to age with dignity. If people are not actively using their minds, they will lose their minds. One example of a different approach would be to have book clubs at the library that are sponsored by a senior center."

"Technology will definitely play a big role in how we engage retirees and seniors in the future. We see an increase even now in the number of seniors who use the Internet to communicate and get information, and that trend will just continue to multiply."

"We need to provide computer training to people who have lower income and education levels (and to non-native English speakers) in order to allow them access to useful medical information. This will be especially empowering for patients with chronic diseases and for patients who are on the cusp of chronic disease."

"It would be great if high schools would get to the point where they would invite older people to come in and learn computer skills or strengthen their computer skills. There needs to be a commitment to lifelong learning. We need to look at more creative partnerships, such as literacy training programs working with the Department of Education."

Need for Ombudsmen

"People need literacy skills to be able to understand what legal and financial documents they are signing, what the doctor says to them, what prescriptions they are taking, and broader life decisions. They are going to need ombudsmen to investigate complaints, interpret information, and help them solve problems. This program should include services to elders who are aging in place, as well as to residents of nursing homes and assisted living facilities."

Education Section References

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Fox, Susannah, March 2004. *Older Americans and the Internet.* Washington, DC: Pew Internet & American Life Project.

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IV. A. 9   Religious Affiliation

A Philadelphia Corporation for Aging analysis of data from the Philadelphia Health Management Corporation 2002 Household Survey found that 90% of older Philadelphians age 65+ reported an affiliation with one of three religions:

- Nearly half (45%) were Protestant (92,130 individuals);

- More than one-third (35%) were Catholic (70,775 individuals);

- One-tenth (11%) were Jewish (22,025 individuals).

Five percent of the sample (10,310 individuals) reported an affiliation that fell into the "Other" category, and 4% (8,939 people) reported no religious affiliation. A very small number of elderly were Muslim.

To obtain a possible future profile for religious affiliation among Philadelphia's elderly, PCA examined data from the same survey for people age 50 to 59, and compared this data to responses from the ages 60+ group. Among the younger group, there were fewer Protestants (39.3% versus 45.0%), Catholics (34.3% versus 35.7%) and Jews (5.9% versus 9.6%) than in the 60+ group. Collectively, these three faith traditions represent 79.5% of the elders in the 50 to 59 age category, a marked decline from the 90% of people ages 60+ who report that they are members of these same three faith traditions.

Using these comparisons as indicators of future religious affiliation, the most striking finding was that more than double the percentage of people age 50 to 59 (9.5%) report no affiliation as compared to 4.7% of those ages 60+. This may mean that the proportion without any religious affiliation as well as those who specifically state that they have no religion will increase in the next decade. However, it has been noted in the literature that religious affiliation tends to increase as people grow older. (Trinity, undated)

Another potential trend that may become more prominent is an increase in the number of older people who are Muslims. The PHMC data indicate that 1.1% of those 50 to 59 years old were Muslim, as compared to only 0.1% in the 65+ group. Also, 1.8% of the 50 to 59 year olds said they were Buddhists, which was a category not tabulated in the 65+ plus group.

Trends for religious affiliation are important. They suggest a more heterogeneous older population, which may be relevant to community service planning. Faith-based service organizations in particular may wish to tailor their services – taking into account this anticipated rise in the number of older people without an affiliation.

Insights from Community Leaders

Research anticipates slight shifts in religious heterogeneity and toward religious disaffiliation. According to community leaders, this data may be relevant to aging service providers.

Shift toward Disaffiliation

"We need to find new ways to look at seniors' spiritual needs and to support religious organizations because they have done community service work forever."

"So many people are not involved in any organized religion where you might get a sense of community. There is a constant need to recreate community for people during retirement – ways for people to come together in small groups which is needed for quality of life. A lot of people don't know who they'll be at retirement. The loss of identity is big."

Intergenerational Religious Programs

"If you have religious institutions and cultural institutions with aging groups here and youth groups there, we should do something intentional to bring them together. Get them to appreciate what they all have to offer and foster a sense of connectedness so that they don't feel alone and disconnected. We want to enable people to be the best they can at every stage of life."

Religious Affiliation Section References

Glicksman, A.and Norstrand, J., 2004. *The Socio-Economic and Health Characteristics of Philadelphia's Elderly Population*. Philadelphia, PA: Philadelphia Corporation for Aging.

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IV. B   Regional Geographic Distribution

IV. B. 1   Urban and Suburban Trends

According to the Delaware Valley Regional Planning Commission (DVRPC), the number of individuals age 65 and older who will live in the Philadelphia metropolitan area will increase by 58% between 1990 and 2025. DVRPC defines this region as encompassing the city of Philadelphia as well as Burlington, Camden, Gloucester and Mercer Counties in New Jersey, and Bucks, Chester, Delaware and Montgomery Counties in Pennsylvania.

The Delaware Valley Regional Planning Commission projects that the geographic distribution of the older population within this region will change significantly, as well. The data shown in the table below reflect an expectation that the elderly population will increase significantly in suburban communities in the decades to come.

Figure 21: Population Age 65 or Older by County, 2000-2025

Population Age 65 or Older by County 2000-2025					
County	**2000**	**2005**	**2015**	**2025**	**% Change 2000-2025**
Burlington	46,088	50,226	67,210	93,169	102
Camden	63,446	64,678	75,805	99,081	56
Gloucester	27,988	29,762	38,655	56,164	101
Mercer	43,294	44,352	52,813	69,855	61
Bucks	67,174	72,918	100,939	145,444	116
Chester	47,056	51,575	73,718	107,792	129
Delaware	84,589	83,885	89,723	108,409	28
Montgomery	109,971	113,662	136,919	177,723	62
Philadelphia	**229,358**	**217,823**	**214,138**	**243,690**	**6**

Source: DVRPC

Note: DVRPC projections differ from Woods & Poole population projections because the DVRPC projections were estimated from the 1990 Census and the Woods & Poole projections are based on the 2000 Census.

By 2025, at least 20% of the population of Bucks, Chester, Delaware and Montgomery Counties will be age 65 or older, and 17% to 20% of the New Jersey suburban counties will be age 65 or above. The DVRPC projects that "…we find that the baby boom generation that charged into the region's suburbs in the 1980's and 1990's are forecasted to age in place, thus greatly increasing the elderly population in the suburbs."

Figure 22: Individuals Age 65+ as a Percentage of Each County's Population (1997 – 2025)

Individuals Age 65+ As a Percentage of Each County's Population (1997 – 2025)				
County	1997 (%)	2005 (%)	2015 (%)	2025 (%)
Burlington	11	12	15	19
Camden	13	13	15	20
Gloucester	11	11	13	17
Mercer	13	13	15	19
NJ Counties	**12**	**12**	**15**	**19**
Bucks	11	12	15	20
Chester	11	12	15	20
Delaware	16	16	17	21
Montgomery	16	15	18	22
Philadelphia	16	15	15	17
PA Counties	**15**	**15**	**16**	**20**
DVRPC Region	**14**	**14**	**16**	**19**

Source: DVRPC, 1999

In raw numbers, Philadelphia will continue to have more residents age 65 or older than its surrounding suburban counties. However, the proportion of projected elderly residents in the city in 2005 (15%) will be slightly lower than some of the surrounding counties (the highest of which in 2005 is Delaware County where 16% of the population is over 65+). In 2025, 17% of Philadelphia's elderly population is expected to be age 65 or older (compared to Montgomery County, where 22% of the population may be 65 or older in 2025).

Figure 23: Percent of Total Philadelphia Region Population Ages 65 and Up, by County
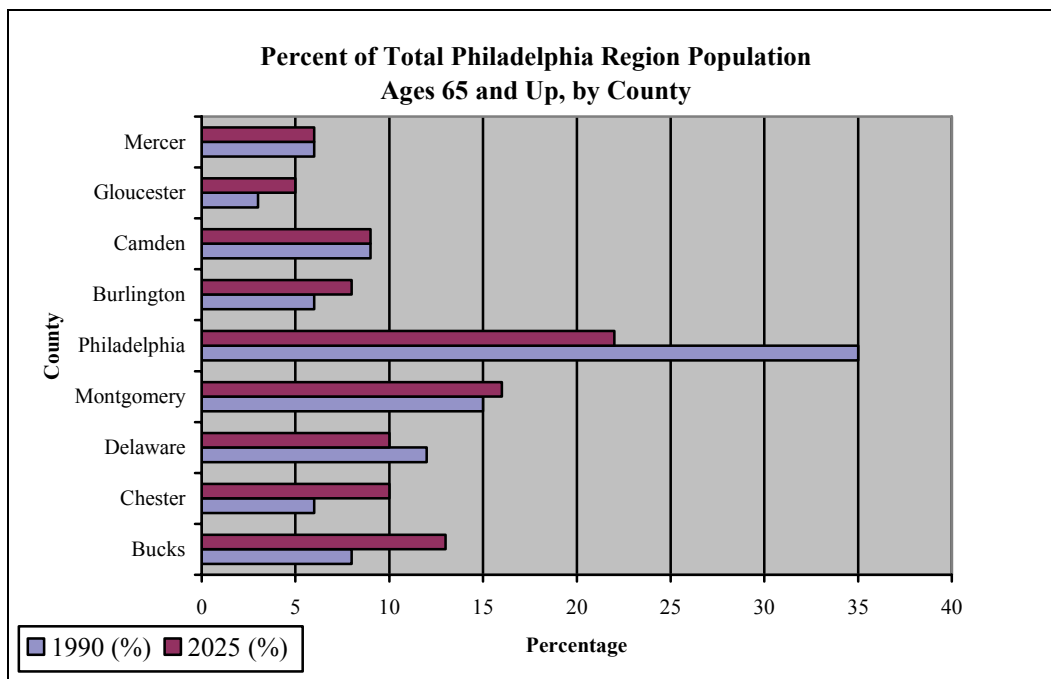
Source: DVRPC, 1999

The eight suburban counties surrounding Philadelphia will account for a greater percentage of the region's older population over time. In 1990, Philadelphia accounted for approximately 35% of the region's older population but it may account for only 22% in 2025. However, two caveats are necessary here:

1) As the DVRPC points out, forecasting within a community is difficult since the construction of a major nursing home, retirement community or assisted living facility can dramatically change the distribution pattern within a municipality.

2) The outflow of people from the city is also difficult to forecast. Two opposing trends have been identified nationally among the young-old (those ages 65 to 74):

   - Some in this age group move from urban areas to presumably cleaner and quieter suburban neighborhoods.

   - The opposite phenomenon is described in an article in AARP's Bulletin (2004). "…Empty nesters join older urbanites where the lights are brighter." This typically occurs among adults whose children have moved out, who then choose to move into cities for easy access and cultural opportunities.

Insights from Community Leaders

Community leaders point to tangible and intangible factors that influence where elderly people choose to live such as convenience, transportation, and community supports. The quality and availability of accessible housing, is an additional and more obvious factor that shapes these decisions.

"We need to create more livable communities where older people can get around and get out for necessities. This means sidewalks in place everywhere and reliable transportation. When there are sidewalks where older people can walk that also means that kids can ride their bikes. The elderly become isolated in their community if they cannot get around safely."

"Seniors may be more likely to move from the suburbs to Center City in the future."

"Many people between the ages of 50 to 55 don't want to move outside Center City. The conveniences are too great. The convenience to get in and out of stores is better. Today's shopping malls are like being at an airport. It's disorienting. Even at a handicapped parking spot you're still talking a quarter mile walk to the true entrance to the mall. Public transit is better in the city, and you can walk from river to river and not fear a problem with undesirables even though they're out there. The perception is different. Police are readily available."

"In some of the neighborhoods that used to have a culture of community awareness, of looking out for your neighbors, I'm seeing that the part of the population that used to look out for each other has moved on. The very frail elderly are left then with younger populations moving in. I'm not sensing that social commitment of looking out for your

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elders. It seems to cut across most groups. I can't say this dynamic is a fact, but it's a perception I have. If you're a working mom, you are so busy trying to take care of your own life that you really don't have much time to look after anybody else."

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III. B. 2   Transportation

"When you start losing your independence, it hurts."   - Focus group participant

"But I notice a lot of times that we lack confidence leaving the house by ourselves. Now I still drive but I don't have the confidence that I had with driving before. I get that fear."   - Focus group participant

"I depend on my son to take me to the store. I can't drive because of my medication so I've become a little more dependent on my family and also on the friends [who] can drive. …Taking away from your independence … you become more and more vulnerable. That's the sad thing about getting old because in [my] mind I still think like I did when I was 16." - Focus group participant

"I was on hold on the phone [with Paratransit, a subsidiary of SEPTA] for 45 minutes waiting for a ride for my husband to go to Presbyterian [Hospital] on Friday. Forty-five minutes. I got so tired of holding my phone, I went and took my portable phone, put it in my ear, and continued to make my dinner. …I cooked most of my dinner while I was holding with the phone like that. They are the worst and your people are rude. Your people are very rude, and they're not on time, they get there early, and if they get there early they expect you to be ready... And if you're not ready, they leave." - Focus group participant

"I've been riding Paratransit for over five years. It's a problem that they don't wait for you. They left me all the way out in Southwest Philly from three o'clock 'til 11:30 p.m. and it's cold, freezing cold out there. I called when you told me to call … and thank God if it wasn't for my daughter, who was with me, and she, we had to walk from where we was all the way down about two blocks, to find a bus, to get on a bus to come back home. And I called them, we called them on our telephone while we's [sic] out there. They kept saying they's [sic] been out there, they there, where you was, and there we were right out in front of the door. They couldn't miss us. You know, but they didn't show up. And that's not the first time, you know, and I have found some nice drivers. There are some that will wait for you and all that. But they do have a problem and I don't think it's only the drivers." - Focus group participant

Transportation becomes an increasingly difficult issue as individual's age. In fact, it consistently ranks among the top needs indicated by older adults. Transportation ranks among the top reasons individuals call the Eldercare Locator, a nationwide directory assistance administered by the National Association of Area Agencies on Aging. (Markwood, 2003)

Older individuals typically lose their ability to drive safely gradually – for reasons that include vision problems, cognitive limitations, side effects of medications, slower reaction times, and muscular difficulties. According to the National Highway Traffic Safety Administration, the number of elderly traffic fatalities is expected to more than

triple by the year 2030, making them 35% greater in number than the total number of alcohol-related fatalities that occurred in 1995.

Many elderly drivers reduce night-time driving, drive only during off-peak hours, avoid driving during difficult weather conditions, and also drive at a slower speed. Mobility is a vital issue for seniors – affecting their ability to fulfill basic needs for food, household supplies, health care, financial management, employment, friendship, recreation, and religious observance.

While most older adults prefer to drive themselves, non-Caucasians are disproportionately unable to drive (reflecting, perhaps, a lower incidence of car ownership and greater use of public transit). Just 16% of Caucasian elders cannot drive compared to 42% of African Americans, 39% of Latinos, and 45% of Asians. Taking into account the anticipated increase in non-Caucasian ethnic groups in Philadelphia by the year 2015, the proportion of non-drivers among the elderly is likely to increase over time.

This can have a significant impact on health care utilization and socialization. For example, non-drivers make 15% fewer trips to the doctor than drivers, 59% fewer shopping trips and visits to restaurants, and 65% fewer trips for social, family or religious purposes. (Bailey, 2004)

Even with these cultural, health and structural barriers to driving by older individuals, according to a 1999 report by the Delaware Valley Regional Planning Commission (DVRPC), *Getting Older and Getting Around,* by the year 2030, nearly 20% of all driver mileage in the Delaware Valley is expected to be attributed to drivers age 65 and over.

Public transportation is more typically used in urban areas such as Philadelphia than in the surrounding suburban region, yet older adults cite a variety of reasons for not wanting to use it:

- Being unable to wait long periods of time, especially if no seating or sheltered waiting area is available;

- Difficulty climbing stairs or standing while a bus or rail car is in motion;

- Reluctance to learn routes, schedules and operating procedures;

- Inconvenience;

- Fear of crime;

- Lack of availability;

- Cost;

- Confusion;

- Visual impairments; and

- Language barriers, particularly for Asians and Latinos.

Research by DVRPC indicates that in 1999 over half the Delaware Valley region's population lived within ¼ mile of a bus, trolley line, or rail station. Another option, demand-responsive paratransit services, is also available primarily for elderly residents who qualify as disabled under Americans with Disability Act (ADA) requirements and who live within ¾ mile of any transit route. The Delaware Valley Regional Planning Commission report indicates that while some paratransit providers have offered rides to non-disabled seniors, "their ability to do so in the face of the anticipated demands of an escalating elderly population is likely to be compromised."

In Philadelphia, paratransit service is offered through the Southeastern Pennsylvania Transit Authority (SEPTA). While no research on elderly rider satisfaction with SEPTA's paratransit service was obtained for this report, participants in the focus groups were vocal with complaints about long and unpredictable waiting times, rude drivers, and unreliable service.

Taxis are another alternative to driving, but this is also the most expensive option – not a helpful solution for Philadelphia's projected growth in its low income elderly population.

The Shared Ride Program is another option for individuals age 65+ in Philadelphia. This program is enhanced by the Attendant Transportation Service which provides door-through-door and upper floor assistance to physically eligible or mentally impaired older people. While the Shared Ride system capacity currently matches present demand, it is difficult to schedule new routine rides and random rides (for instance for medical appointments or shopping). There is a need to boost capacity for this program to meet anticipated growth in demand.

Solutions to anticipated future difficulties in transportation are complex, requiring a myriad of minor and major systemic changes in transportation, services, and planning processes. One solution may be to increase funding and service quality for on-demand transportation services for the elderly (a variety of model programs in other cities that provide on-demand service are described in the DVRPC report, including independent transit networks for seniors using automobiles and vans, and taxi discount programs).

More systemic changes in roadways and alternate transportation nationwide may alleviate transportation-related difficulties for the elderly. In addition to integrating mobility for the aging population into transit projects and services, transportation and neighborhood planning should incorporate better lighting, signs and signals for older drivers and pedestrians. In addition, community planning efforts should be encouraged to address issues of safety and walkability including curb cuts, smooth sidewalks, bus shelters and benches.

Additionally, the license process and cars themselves could be modified to improve safety among elderly drivers. The license renewal process for older drivers could involve more rigorous re-testing, re-training and re-licensing requirements for the near elderly and elderly populations. Cars could be modified with larger rear view mirrors, swivel seats and redesigned doors to provide easier access to the vehicle.

Additionally, senior citizens and the near-elderly should be counseled to realistically plan for the day when they will no longer be able to drive.

Finally, more than half of older Americans make walking a regular activity, 4% of older Americans ride a bicycle at least once a week, and nearly two-thirds walk a half mile at least once a month. Funding should be increased for 'Transportation Enhancements' the only federal program that focuses specifically on pedestrian and bicycle safety and facilities. The program provides vital resources for pedestrian-friendly improvements.

Insights from Community Leaders

Adequate transportation is a lifeline for the elderly, especially for those living independently, according to community leaders who point to a number of ways the existing transportation system could be improved.

Need to Improve Existing Transportation

"Transportation is especially important if we are going to allow people to age at home. People will be isolated in the community if they cannot get safely around. Isolation is already an issue, and its importance will grow as the elderly population grows.
We need to improve the transportation services that are available now. They're not fully equipped to meet the current needs of the elderly who need reliable, affordable transportation to socialize, get groceries, and run their daily lives – not just to attend medical appointments."

"Transportation is critical to the elderly. Our transportation system could crumble without increased funding. This would crush any hope of employment for many elders, and would increase their isolation and vulnerability to being victimized."

"You can have all the senior services in the world, but they're useless unless you can get people there. We need to be able to perfect the current system so that it is consistent, available and run efficiently. "

"There is unmet need for attendant transportation, which is the two-person assist transportation. But it's expensive and complex to coordinate."

"In Philadelphia we are fortunate to have a fairly decent fixed route system that is essentially free for people age 65 and over except during peak hours. We also have Shared Ride service which is funded through the lottery and is available throughout the state. One of the challenges for Shared Ride is to make sure it is as responsive as it can be. Turnover among drivers has tended to disrupt regular schedules. New drivers might not know streets which could cause frustration among people who use it."

"Right now Shared Ride drivers can help people down the front steps and into the vehicle. But as the older population ages, we will see more frailties that need to be addressed. Philadelphia does have limited attendant transportation services so that the

attendant and driver if necessary can carry a person from the second floor and down the steps because Philadelphia's housing is not designed for quick and easy access. But there is going to be much more need for that kind of assistance in the coming years."

"Transportation providers see their role only as transportation, and it's more than that because you're looking at a whole host of needs that elderly people have. It's more than transporting from Point A to Point B. We need to look at the type of training drivers get to make sure they are sensitive to the needs of the elderly. There are people riding on public transportation who have dementia, missing limbs, deafness, blindness and a whole host of different kinds of limitations. Drivers have to be prepared to deal with all that. To be able to negotiate driving the streets while being appropriate with passengers is a difficult job."

"SEPTA is working in the right direction. I know older people move into Philadelphia because of its public transportation and not needing to have a car. All the SEPTA buses are now handicapped-accessible. But SEPTA still has to get its act together with the El and the subways and make all of them handicapped accessible. They are working toward this, but it's taking too long."

"Philadelphia has a cab system that's tremendous. The convenience to hail a cab with ease is amazing. You can't get that in the suburbs."

"The issue of mobility is a serious concern in the suburbs where public transportation is not as readily available."

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IV. C   Economics

IV. C. 1   Poverty Rates and Income Levels

> "We are all going to be in a worse situation.   Insurance goes up. There is no interest if you have money in the bank. Social Security is not going up. Yearly expenses are much higher.   If there is no income, things are going to get worse." – Focus group participant

> "I worked all these years, paying into the system. You mean to tell me that I have to make a choice of whether to use the little bit of money they give me for Social Security for my medicine so I can stay alive, or keep a roof on my head so I can live, have shelter from the storm?" - Focus group participant

Given that Philadelphia as a whole struggles with poverty, it is likely that the problem will persist among the city's seniors in the next decade. Overall, Philadelphia is the seventh poorest city in the U.S. One-third of its 540,000 households lived on $18,332 a year or less in 1999. In 2000, more than 22% of the city's residents of all ages lived below the poverty line, a 2% increase from the previous decade. (Brookings, 2003) Between 1979 and 1999, the proportion of high-income households in Philadelphia dropped by 20%, while at the same time the proportion of city households classified as low-income increased by 15%.(Gorenstein, 2004)

Similarly, older Philadelphians are disproportionately poor compared to the elderly nationwide, in a trend that may be intensifying. Between 1990 and 2002, the proportion of individuals age 65 and up living in poverty increased from 16% (37,907 individuals) in 1990 to 19% (39,155 individuals), according to the Philadelphia Health Management Corporation. The Brookings Institution reports a more gradual rate of increase, from 16% in 1990 to 16.9% in 2000.

Nationally during that time period, the opposite trend unfolded. Rates of poverty among the elderly nationally declined from 12.8% of people age 65 and older in 1990 to 9.9% in 2000 – or nearly one in 10 elderly individuals living in poverty in that year. (Brookings, 2003) By comparison, in the year 2002 in Philadelphia, at least one in six elderly individuals was living in poverty.

Philadelphia's poverty rate is also significantly higher than the poverty rate among the elderly throughout the state of Pennsylvania. In 2002, 19% of Philadelphia's seniors lived in poverty, compared to 11% of Pennsylvania seniors age 65+ in that same year. (Henry J. Kaiser Family Foundation, 2004)

Poverty among the elderly varied by ethnic group in Philadelphia between 1990 and 2000. The poverty rate among elderly Caucasians rose slightly, from 12% to 13% between 1990 and 2000. Among elderly African Americans, the poverty rate declined

from 26% to 22% between 1990 and 2000. Poverty rates among elderly Asians rose from 20% to 28% in that same time period. (Philadelphia Health Management Corporation, 2002)

Data for poverty among elderly Hispanics in 1990 were not available. However, the rate is likely to be significant because Philadelphia has the highest Hispanic poverty rate (all ages) among 23 U.S. cities being studied by the Brookings Institution.

Figure 24: Poverty by Ethnic Group among Philadelphians Age 60+

Poverty by Ethnic Group among Philadelphians Age 60+ (Percentage of total within ethnic group)					
	1990		**2000**		
Ethnic group	**Total**	**Percent**	**Total**	**Percent**	**% Change**
Caucasian	18,525	12	16,215	13	+ 1
African American	18,149	26	15,769	22	- 4
Asian	440	20	1,019	28	+ 8

   Source: Philadelphia Health Management Corporation, 2002

There are no forecasts for poverty among Philadelphia's elderly for the coming decade. However, based on current trends, it is possible to infer that poverty will be an unrelenting problem for the city's elderly. At present, 17% of 50 to 59 year olds in Philadelphia live in poverty, while 19% of Philadelphians age 60 and older live in poverty. (IPUMS, 2000) As the 50 to 59 year old group ages, incomes are likely to decrease (as they fall out of the labor force) and some may fall into poverty level. Population increases are forecast for the groups most vulnerable to poverty in Philadelphia: non Caucasians, women and individuals over the age of 85.

Participants in consumer focus groups name financial worries as their top concern. In particular, they focus on the cost of health insurance, prescription medication, home repairs, utilities and real estate taxes. Even small increases in these expenses can cause significant burdens for people living on fixed incomes.

Most focus group members expect that they'll have just enough to live on or that they will be struggling in five years or at age 75. African Americans with less than a high-school education, as well as African American and Caucasian participants whose sole source of income is Social Security, were most likely to mention financial concerns.

Very few focus group participants were confident about their financial future. Individuals without concern typically had pension or investment income or health or prescription medication insurance as well as higher incomes and better educational attainment. Mainly due to the expense, only a minority had taken steps to prepare for the future, such as writing a will, consulting a financial planner or purchasing long-term care insurance.

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Income Projections

Income projections for Philadelphia's older population for 2015 also are not available, but forecasts through 2009 provide insights into possible trends over the next five years. Forecasts obtained from Claritas Inc. (Senior Life Report 2004) anticipate median income increases of 9 to 11% among Philadelphia seniors over the next five years. But it should be noted that these are not inflation-adjusted dollars.

The Claritas forecast also indicates that median incomes will decline with age. For example, households age 60 to 64 have a median income of about $35,000 in 2004. But the median income in households age 85 or older is just $17,000. A similar decline in household income by age is expected for 2009, when the median income among 60 to 64 year olds is expected to be $38,000, while the forecasted median income among those ages 85+ will be just $19,000.

Figure 25: Philadelphia Households Median Income by Age

Philadelphia Households Median Income by Age - 2000-2009				
Age of Householder	**2000 Census**	**2004 Estimate[1]**	**2009 Projection[2]**	**% Change 2004-2009**
55-59	$36,015	$37,261	$40,669	9.1
60-64	$33,155	$35,007	$38,315	9.4
65-69	$24,541	$26,142	$28,898	10.5
70-74	$23,157	$25,092	$27,818	10.8
75-79	$20,353	$21,977	$24,273	10.4
80-84	$18,251	$19,765	$22,030	11.5
85+	$15,571	$16,995	$18,974	11.6
Total Population				
All Ages	$31,011	$32,769	$36,061	10.0

Source: Claritas, 2004
[1] Estimates are data prepared for the current year.
[2] Projections, sometimes called forecasts, are prepared for dates five years in the future.

The tables below show trends in projected income levels between 2000 and 2009 for individuals ages 55 to 64 and people age 65+.

Figure 26: Philadelphia Household Income, Ages 55 to 64

Philadelphia Household Income, Ages 55 to 64 Actual and Projected: 2000-2009						
Household Income	2000 Number	% of Households	2004 Estimate[1]	% of Households	2009 Projection[2]	% of Households
Less than $15,000	19,059	24.7	20,072	24.2	19,826	22.3
$15,000 to $24,999	9,810	12.7	9,693	11.7	9,745	11.0
$25,000 to $34,999	10,028	13.0	10,674	12.9	10,100	11.4
$35,000 to $49,999	12,137	15.7	12,420	15.0	13,758	15.5
$50,000 to $74,999	12,332	16.0	13,296	16.0	14,315	16.1
$75,000 to $99,999	6,646	8.6	7,573	9.1	8,529	9.6
$100,000 or more	7,164	9.3	9,334	11.2	12,501	14.1
Total Households	**77,176**	**100.0**	**83,062**	**100.0**	**88,774**	**100.0**

Source: Claritas, 2004
[1] Estimates are data prepared for the current year.
[2] Projections (or forecasts) are prepared for 5 or more years into the future.

Figure 27: Philadelphia Household Income, Age 65+

Philadelphia Household Income, Ages 65+ Actual and Projected: 2000-2009						
Household Income	2000 Number	% of Households	2004 Estimate	% of Households	2009 Projection	% of Households
Less than $15,000	53,337	37.0	47,391	35.1	42,220	31.5
$15,000 to $24,999	29,766	20.6	26,725	19.8	25,823	19.3
$25,000 to $34,999	18,829	13.1	18,674	13.8	18,322	13.7
$35,000 to $49,999	17,271	12.0	16,412	12.2	18,460	13.8
$50,000 to $74,999	13,701	9.5	13,197	9.8	14,106	10.5
$75,000 to $99,999	5,580	3.9	6,152	4.6	6,830	5.1
$100,000 or more	5,676	3.9	6,459	4.8	8,224	6.1
Total Households	**144,160**	**100.0**	**135,010**	**100.0**	**133,985**	**100.0**

Source: Claritas, 2004

The tables show modest changes in income distribution between 2000 and 2009. Among *households age 55 to 64* (typically pre-retirement years), the proportion with incomes of less than $25,000 will drop 4%, from 37.4% in 2000 to 33.3% in 2009. The proportion of households in the middle categories will remain fairly constant. And the proportion of households with incomes of $75,000 or above will increase 6%, from 17.9% in 2000 to 23.7% in 2009.

Not surprisingly, reaching retirement age has a dramatic and negative impact on income. However, the Claritas data which are not adjusted for inflation, do show a decline in the number of *households age 65 and up* with income of $25,000 or less – from 57.6% of

households in 2000 to an estimated 50.8% of households in 2009. An approximately 3% increase is expected in the proportion of households with incomes of $35,000 to $74,999, and similarly a 3% increase is expected in the proportion of households with incomes of $75,000 and up.

Household Value for Philadelphia Seniors

Often, an older person's home is his or her largest financial asset. The median value of homes owned by seniors in Philadelphia is $55,000. The homeownership rate among Philadelphians age 60 and older is 78%, comparable to the homeownership rate nationally. (AOA, 2003)

Insights from Community Leaders

Poverty levels among Philadelphia's future elderly population are already significant and are expected to grow – raising a complex array of issues related to financial planning, health care, and the need for outreach, counseling and education for individuals facing retirement in the coming decades.

Economic Forecast for the Region's Elderly

"Income forecasts for the Philadelphia region's elderly should concern people who live and work in the city today. Poverty among the elderly will strain city services and budgets."

"The differences between Philadelphia's haves and the have-nots seem to be growing. The poor people are going to keep getting poorer, and more people are going to be poor. They will be more distant from their affluent counterparts geographically and also in their mental health and physical health status, everything…"

"The gap is going to get bigger in the city between low income and middle income. There isn't going to be anything in-between there. The skill level required for middle income jobs will escalate while people at the lower end won't be able to sustain themselves. You are always going to have the Walmart and McDonalds jobs, but unless you have 3 or 4 adults working those types of jobs who can pool their resources, you can't live on your own on the salaries people earn at those types of jobs. Dependency on the social service system is going to be greater."

"There is a definite wealth and education drain from the city. The city's population is shrinking and for a reason – crime and the school systems. You have to address the issues as to why people are moving out of the city. These issues are huge. With resources such as supermarkets, stores and decent jobs moving out of the city and reluctant to reenter, we are definitely lacking in supporting services in the city, especially in areas like North Philadelphia. Crime is also a huge deterrent; and it's related to people not having jobs."

"Maybe there is some manipulating we can do with our tax structure to get people back into Philadelphia to work, but I am not too optimistic about that. So goes the nation, and so goes the cities. Some of this is beyond the purview of our regional government, and some of this is beyond our national government. This whole geo-political economy has to play itself out."

Health Care and Social Security Affect Retirees' Finances

"We have seen a decline in the number of employers offering employment-based health insurance. How many retirees will wind up in this cohort – people who expected to have retiree health coverage that just won't be there? Are there more Bethlehem Steels on the horizon?"

"There are going to be a lot of baby boomers who get stuck in the gap – who can't private pay for health care and who don't qualify for Medicaid. There is a real danger of an increase in the divide between the medical haves and have-nots in terms of who can afford new treatments and drugs."

"Over the next 10 years, public policy issues need to be resolved with respect to what kind of health care system we have, how it is paid for, and the respective roles of individuals, insurers and the government. Everything I see suggests that the costs of health care will just continue to increase unless there are some changes made at the federal level."

"What is going to happen to Social Security if the Bush Administration succeeds in privatizing it? That remains a source of controversy. Social Security and Medicare have kept many people out of poverty all these years. Will that be there, and will there be enough voices to defend and expand it?"

"Social Security and the cost of health care are issues that need to be dealt with at the national level. How these issues are resolved will fundamentally affect the financial security of Philadelphia's elderly in the decades to come."

"Privatizing Social Security will increase poverty."

Outreach, Financial Planning Needed

"People have unrealistic expectations about how they will support themselves and survive in retirement. We need to encourage people to … do realistic financial planning."

"There are a number of options available to low income people that are not available to middle income people at this point."

"Right now, we are ignoring a group of elders who have moderate rather than severe financial needs. They need financial counseling so that they can find out if they will be

able to pay for services that they might not be eligible for otherwise. How people spend their money is a big issue. The postwar generation is already notorious for outliving its assets. People do not like to plan for the future, often due to money worries."

"There is a huge need for education on how to plan ahead for retirement. Most people aren't doing planning, saving and research. There's still a lot of denial. There is an opportunity now to educate boomers on how to best plan for the future. Because some people won't have enough money to retire, they will be working longer and retiring at a later age. The future strength of the economy and the performance of our 401(k)s will determine whether we can afford to live independently."

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IV. C. 2   Employment

"That financial thing is really hitting the nail on the head as far as income cut … in half or less, after they leave the environs of employment. … I had to sit down … almost in tears one day when I realized I was broke. I'm broke. I'm not going to get another check until … four weekends" – Focus group participant

"…If you have not prepared, or you have always been in a low-paying job, or have no inheritance, if you have not planned… if you're not old enough for Social Security or Medicare. …You find yourself in that void. … The financial adjustment as you get older is a real situation." – Focus group participant

"I'll be 70 next month; and I have two small grandchildren, one eight months and one two years old. My children have to pay me to watch the two [grand]children while they work. I cannot make ends meet with $800 a month Social Security. ... When that [childcare job] stops, I don't know what I'm going to do. … It scares me." – Focus group participant

National Forecast

National surveys indicate that many workers expect to remain engaged in work well beyond the traditional retirement age of 65. (Rix, 2004) In fact, the Bureau of Labor Statistics projects that labor force participation by older adults is likely to rise gradually from 2002 to 2015. As shown in the table below, the proportion of adults ages 65 or older who are still working is likely to grow from 13.3% in 2002 to 16.2% in 2015. The proportion of adults ages 55 to 64 who are employed is expected to remain stable from 2002 to 2015, at about 61%. (Rix, 2004)

Figure 28: Percent Labor Force Participation for Persons 55 and Older

Percent Labor Force Participation for Persons 55 and Older - 2002 – 2020				
Sex and Age	2002 (%)*	2010 (%)	2015 (%)	2020 (%)
Both sexes				
55-64	61.8	60.9	61.6	60.8
65+	13.3	14.8	16.2	16.3
Men				
55-64	69.2	67.0	66.8	66.1
65+	17.8	19.5	21.0	21.0
Women				
55-64	55.1	55.2	56.7	55.8
65+	9.9	11.1	12.5	12.6

* Actual data for 2002, forecasts for 2010-2020.

Source: Adapted from US Department of Labor, Bureau of Labor Statistics, January 2003; Toossi, 2002. Cited in Rix, 2004.

Subtle differences emerge in workforce participation projections for older men and women by the year 2015. The proportion of men in the workforce between the ages of 55

to 64 is expected to decline gradually from 69.2% in 2002 to 66.8% in 2015. In contrast, workforce participation among women ages 55 to 64 is expected to rise slightly from 55.1 in 2002 to 56.7% in 2015. Among men ages 65+, labor force participation is expected to increase from 17.8% in 2002 to 21% in 2015 and, among women ages 65+, workforce participation is expected to rise from 9.9% in 2002 to 12.5% in 2015.

A more compelling trend emerges when the size of the older population projected for the year 2015 is factored together with the expected increase in labor force participation by this demographic group. <u>Viewed as a proportion of the total workforce, in 2002, people age 55 or older accounted for 14.2% of the American workforce. By 2015, the same age group will comprise 19.2% (nearly one in five) of all workers and job seekers.</u> According to the General Accounting Office, these workers will account for a rising proportion of occupations such as teaching and nursing. (Rix, 2004)

A 2004 AARP report, *Aging and Work - The View from the United States* suggests a variety of reasons that would lead adults to stay in the workforce past traditional retirement age, including:

- Stagnation or decline in pensions and defined benefit payments;

- Uncertainty in the stock market;

- Insufficient savings;

- Cutbacks in health benefits for retirees; and

- Higher educational attainment, which is correlated with later retirement.

Additional widely recognized factors in 2004 that may add to older Americans' anticipated future financial difficulties include the growing U.S. government deficit and potential changes to Social Security.

Older Philadelphians' Workforce Participation

Approximately 10% of Philadelphians age 60 or older who participated in the 2002 PHMC Household Health Survey were still in the workforce. Six percent were employed part time and 4% were employed full time. The vast majority (82%) of survey participants age 60 or older were retired. Five percent were unable to work; and 3% were unemployed or homemakers. Within the sample, a greater proportion of men (91%) were retired than females (77%), and a slightly greater proportion of African Americans were retired (87%) than Caucasians (82%). (Glicksman and Norstrand, 2004)

Future workforce participation for Philadelphia's elderly will be influenced by an intricate mix of socio-economic and demographic variables, and more specifically by each individual's need, ability and willingness to work. However, a series of anticipated changes (detailed in many sections of this PCA report) do suggest that Philadelphia's older population may experience serious economic difficulties by 2015.

Anticipated contraction in labor force growth may expand opportunities for adults who want or need to work in their later years. The growth in the overall size of the U.S. labor

force is anticipated to taper off in the next 50 years. Labor force growth was 1.6% between 1950 and 2000. This growth rate is expected to slow to 0.6% between 2000 and 2050. (Toossi, 2002) During these five decades, employers may begin to face shortages of younger workers and may also begin to offer inducements – such as part-time schedules, flexible work arrangements or more gradually phased-in retirement options – that will be attractive to older workers. (Rix, 2004)

Insights from Community Leaders

Working beyond traditional retirement age will offer a needed economic boost for many elderly Philadelphia residents in the years to come. Regardless of whether they will be paid or volunteer workers, organizations will need to think creatively and flexibly about elderly workers' responsibilities, training, supervision and hours.

Income and Civic Engagement

"More people will be working at age 65 – many because they will need the money and others because they just want to be engaged in a meaningful way. Most companies and service organizations haven't thought about how to use volunteers and how to support paid positions for the elderly in their programs."

"People are going to work later because of the rise in health costs. Employment provides security in terms of health benefits."

"Most people are going to continue working and are going to be looking for bridge jobs – not the stressful jobs they had during most of their career, but jobs that will help them both with self-esteem and financial stability. They really don't believe they will be able to make it without this involvement."

"We need to facilitate employment for seniors – many of whom live in borderline poverty that can be helped by employment. People need money and a productive outlet. Some employers are offering retirement packages including a period of part-time employment, a sort of un-retirement. We need way more options for new careers during retirement."

"When people live longer and are healthy in their old age, it raises the question of how will they be able to support themselves financially. Will they need second careers or can they pursue volunteer opportunities that allow them to use their skills?"

"We need to offer training for old people returning to the workforce to help them find meaningful work. Employment is not just about a wage. It's a way to create civic engagement and meaning."

Flexibility Needed for Working Seniors

"People are more likely to work longer and have a later retirement. There will be more 60 to 65 year olds in the workforce at some level. If senior centers offer services to these

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people, they need to be more flexible – offering those services on Saturdays or between 5 pm and 9 pm, for example, and not just between 9 am and 3 pm."

"A lot of boomers want choice – the freedom to do what they want to do when they want to do it – and that has enormous implications for people who want to engage older people as volunteers or in part-time paid employment. We need to help people live for around 30 years beyond the traditional age of retirement in a way that is fulfilling and meaningful for them."

"These are people who have had real responsibilities and have a lot to contribute in their senior years. There ought to be places they can go if they don't want to work full time, and want more flexible hours. The elderly need opportunities to contribute. We have a long way to go in offering meaningful, real and appropriate work, training and supervision. There is a lot of opportunity to engage the elderly in paid or volunteer responsibilities."

Employment Section References

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Toossi, M., 2002 (May). *A Century of Change: The U.S. Labor Force 1950-2050*, Monthly Labor Review.

IV. C. 3 Housing

"We have looked into moving because … the stairs are really bothering me and my neighborhood has gone down, way down. And being on a fixed income … you can't afford a lot of these places. They're so expensive. We just looked into one … last week [for] $250,000. At my age, who's going to get a mortgage? … What they need is something that's more in people's range, but I don't think we're going to get that." – Focus group participant

"They're building all these new retirement homes. … I think they should have more for people with low incomes. Some place for them to know that they're secure until they die." – Focus group participant

"I would imagine that if I'm 75 my biggest thing… The worries are the gas and the electric… and so that would probably be my thing about worrying about staying in my home. Will I turn on the air conditioner? Even though I'm only 50 something, I worry now… So if I'm doing that now, at 75, I know I will be too scared with the little income to turn it on. So, and then it will be the same thing with the heat… You turn the heat down and you have all these blankets… If I'm living in my home, that's what I'll do." - Focus group participant

"[In five years I expect to be] in my own home. As long as I can afford it. Everybody's trying to talk me into selling the house, and go buying a condo. I say, "No." It's my house, it's what I worked for all my life. I don't want to give it up." – Focus group participant

"… All I want is a single home.. I need a one-level home. One where I don't have to chase up bathroom steps and stuff like that. That's, you know, what I'm visualizing." – Focus group participant

"Everybody say I live in a senior building, you know, and I have a beautiful place, it's nice. I knew some people, friends of mine who have houses…; they're gonna take all your money. I don't worry about nothing. I pay my rent… and anything doesn't work when I wake up, I pick up the telephone, and most of the time… they say, we going to send somebody…" – Focus group participant

"It's too expensive. They want an arm and a leg to get in. Like 55 and older communities. You sign your life away and you start $150,000 just to get in. Then you've got your maintenance after that, you've got to pay a fee after that, and you know it's unbelievable." – Focus group participant

Older individuals, both nationally and locally, face complex challenges in the realm of housing. Among the challenges are: lack of affordability, deterioration of urban housing stock and surrounding urban neighborhoods, and inadequate access to supports for independent living as age-related physical and mental health difficulties lead to increasing impairment.

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Compounding these difficulties (which represent a continuation of problems faced by older Americans and Philadelphians over the past few decades), the region is also expected to follow national trends over the next 20 years in the following ways:

- Increased numbers of older Philadelphians;

- Higher proportions of non-white individuals and immigrants among the elderly population;

- Increased numbers of elderly women living alone;

- Increased diversity of household and family relationships.

The problems become even more critical with the shift from institutional to community-based care for frail elders – a shift that depends on appropriate housing for seniors with physical health, mental health and functional needs. Numerous studies have shown that the majority of older people prefer to remain in their homes for as long as possible. A suitable housing environment is fundamental to an older person's ability to remain in the community.

Nationally, the number of households occupied by seniors is expected to grow by nearly 53% from 2000 to 2020. As shown in the table below, the greatest growth during those two decades is expected to occur in owner-occupied households (61%), with more modest growth in renter-occupied households (22%). Already, there is a critical shortage of decent, safe, sanitary and affordable housing for seniors across the U.S.

According to the Commission on Affordable Housing (2002), the supply of housing for seniors with modest incomes has declined. Thousands of units of subsidized housing have been lost nationally due to privatization and deterioration in recent years. If this shortage continues, it will be of greatest concern to non-Caucasian seniors who tend to have lower incomes, and also to seniors with disabilities who need accessible supportive housing.

Figure 29: National Household Growth Projections: 2000-2020

National Household Growth Projections: 2000-2020				
Year and Age Groups	**Owner Households**	**Renter Households**	**Total Households**	**Ownership Rate**
Year 2000				
65-75 yrs	9,470,000	1,972,000	11,442,000	82.8
75 yrs and older	8,784,000	2,637,000	11,421,000	76.9
2000 Totals	18,254,000	4,609,000	22,863,000	79.8
Year 2020				
65-75 yrs	16,880,000	2,790,000	19,670,000	85.8
75 yrs and older	12,424,000	2,838,000	15,262,000	81.4
2020 Totals	29,304,000	5,628,000	34,932,000	83.8
% change 2000-2020	**+61**	**+22**	**+53**	**+49**

Source: "State of the Nation's Housing 2001," Joint Center for Housing Studies, Harvard University (2002) cited in Commission on Affordable Housing (2002)

According to the City of Philadelphia Office of Housing and Community Development (OHCD), Philadelphia already faces a housing crisis, largely because of two factors:

- The deteriorated condition of the city's occupied and vacant housing stock;

- The shortage of housing units priced at sales and rent levels affordable to low and moderate-income households. (OHCD, 2004)

In Philadelphia, most existing homes are two- or three-story row houses with steps leading up from the sidewalk, more stairs within the home, no first floor powder room or bathroom, and doorways that are too narrow to accommodate wheelchairs or walkers. For both homeowners and renters, housing suitability and affordability create obstacles to maintaining independence.

Philadelphia has a high rate of homeownership by seniors. Among those age 60 and older, a clear majority, 78%, own their own homes and 22% rent. According to the Office of Housing and Community Development, seniors over the age of 65 in Philadelphia account for 30% of the total homeowners in the city. (OHCD, 2004) The median value of homes owned by Philadelphians age 60 or older is $55,000.

However, the quality of Philadelphia's housing stock has declined. Half (53%) of older Philadelphians live in houses built before 1940, and 17% live in homes built in the 1950s. Many of these dwellings have deteriorated and need major repairs. (IPUMS 2000) Rental properties occupied by seniors tend to be newer but repair needs are still significant.

The 2002 PHMC Community Health survey inquired about the need for repairs to selected aspects of the home. The findings documented that 13% of senior home owners felt that their plumbing needed repairs, 12% thought their roof required repair and 7% said that the heating/cooling system needed attention. Just under half (47%) of older adults rent units built from 1950 to 1979, but one-fourth (28%) live in structures built before 1940. Renters' repair needs include plumbing (16%), roofing (7%) and heating (8%) repairs. In addition to repairs, many older homeowners use adaptive devices and/or need environmental modifications to their homes to be able to retain independence as they experience functional losses. Of the devices asked about, 24% are estimated to use grab bars, 22% use a bathtub seat, 14% use a raised toilet seat, 13% use a commode and 17% use railings on the wall. Counting across all 5 devices, 47% use at least one.

Older renters also face significant housing challenges, including a lack of affordable housing, and the need for repairs and home modifications in rental apartments. The City of Philadelphia Office of Housing and Community Development (OHCD) estimates that approximately 70% of low-income elderly rental households have housing problems, defined as living in units that have physical defects, are overcrowded, or where cost is a burden. The need for repairs and modifications to rental housing are complicated by landlord-tenant issues and funding restrictions.

Unfortunately, elderly renters have few options, as there is a serious shortage of affordable and accessible rental housing in the city. In December 2002, PCA conducted a phone survey of 22 subsidized housing facilities and found that more than 2,000 people were on the waiting lists at these facilities alone.

Focus group participants shed additional light on the situation. Most are committed to staying in their own homes and maintaining independence for as long as possible, yet the cost of utilities, home repairs and taxes put these goals in jeopardy. The problems are especially acute for adults living in older, deteriorated housing in low-income neighborhoods.

Focus group participants in their 50s and early 60s generally had made no plans for supportive services or adaptations. Many in their late 60s and 70s already had moved to smaller homes and apartments or were planning to do so in the near future. Those who do move are more apt to choose rental housing, because they feared high monthly mortgage payments or condominium fees that are subject to steep increases.

Barriers to moving include: wanting to own property that will pass to the next generation through inheritance and a lack of affordable subsidized senior housing. Some participants are reluctant to move in with grown children for fear that they will be a burden to them. Most perceive retirement communities as unaffordable. Because of poor quality care and high cost, nursing homes are seen only as a last resort.

With Philadelphia's age demographic skewing increasingly older, continued and increased demand among Philadelphia's seniors is anticipated for housing repairs assistance, subsidized housing and supportive housing.

Insights from Community Leaders

Philadelphia's elderly live in settings that span the continuum from independence (owner-occupied homes) to dependence (nursing homes). Interviews with community leaders point to subtle and glaring issues associated with each of these types of housing.

Housing Stock

"We know from detailed analysis that the availability of affordable housing for low income people in Philadelphia is at a crisis level. For the elderly, there is a lack of affordable housing; the little bit that still exists is not physically accessible for people with mobility impairments. The 'double whammy' is that while the city is trying to address this population's needs, it is vastly under-funded and understaffed to do so."

"Philadelphia's housing stock is not designed for old, old people. Bathrooms are on the second floor and the laundry is in the basement."

"The City of Philadelphia is the only major metropolitan area in the U.S. that does not have a housing trust fund which is an innovative way to bring private and public dollars together to help developers build affordable housing. This program needs to reflect the input of advocates and service providers for it to receive the full support of City Council and obtain dedicated funding."

"Philadelphia's housing stock has a lot of repair problems and in general is unsuited to people with disabilities or any kind of frailty. The continuing decline of the city's population has resulted in a shrinking tax base. The question in Philadelphia becomes: if you have such a large elderly population, where are the taxes going to come from to support programs that will address their housing needs?"

"People living on Social Security and limited savings cannot afford to fix the furnace, replace the roof or do the higher end maintenance necessary to maintain the inhabitability of their homes. The city needs to continue to commit the funding programs that make these repairs possible, such as the Basic Systems Repair and Adaptive Modification Program under the Neighborhood Transformation Initiative."

"All you have to do is sit in our hospital's emergency room for a few days. You'll see so many elderly patients who have no desire to leave because being there means having heat and the possibility of a meal. That's one reason I know that housing is still one of our community's basic unmet needs."

"Our parents' generation paid for their homes early. When they retired, their homes were paid for and they didn't have that mortgage. Now we're getting mortgages later in life. With the skyrocketing cost of real estate, by the time we get to retirement age the older citizens who still have mortgages may have to go through foreclosure. Subsidized housing should really be a part of our future planning."

Design Issues

"Business in general has got to find ways to make their buildings more accessible."

"How can we get sidewalks everywhere for children and adults?"

"Simple things like changing a crosswalk, rethinking the timing of crosswalks, making it a longer time ... can help in some locations".

Urban Flight

"As people who are educated and mobile leave the city, we are left with people who don't have as many options economically who have to stay. They have to age in place, in older housing stock that is not in good shape."

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Housing Scams

"We need to educate older people in the city so they don't fall victim to housing scams. When elderly homeowners are duped into refinancing their homes and are not clear about what they are signing, they end up with financial problems or foreclosure types of issues. Our legal service providers have seen a bit more of that in recent years."

"There is a rash of predatory lending, with sub-prime mortgages being targeted to poor credit risks. Firms are marketing home equity loans where people finance their entire home equity and then have to pay high fees and interest. If they can't collect the money immediately, the home is foreclosed. This is an epidemic all over the U.S. and in Philadelphia especially because elderly homeowners are 'equity rich.' The elderly usually don't understand the amount of the mortgage, use the cash from the refinance to pay off their other debts, and then find that they can't pay their monthly bill."

"There has been an explosion of foreclosures. There aren't enough legal services to represent everyone who needs it."

"We are seeing an increasing number of people being evicted and sued for unpaid bills by their nursing home. When people go into nursing homes, the application process is pretty confusing. A poor job is done explaining to people. So people get a partial picture, don't understand, are confused, and do things wrong."

"What we have also seen recently is that the nursing homes are going after family members. Recently, a man's mother was being admitted to a nursing home and his daughter had power of attorney. They told him he had to sign or his mother wouldn't be admitted. He signed, and actually what he had signed was a statement that he had access to her funds which he didn't. When something went wrong it was out of his control and out of his daughter's control. The nursing home sued him. That violates the Social Security Act. We have a whole bunch of these cases. And there are so many people who can't afford an attorney and get judgments against them and a lien on their home."

"Nursing homes want to discharge people to Alzheimer's units and send them anywhere or to the hospital. Then they refuse to take them back. They are not allowed to do this, but unless you have an advocate standing there beside you, they get away with it."

Visitability

"One common sense solution is to require all government-supported housing units to incorporate "visitability" in its design, meaning that it could easily be inhabited or visited by someone in a wheel chair. Specifically, this would mean at least one entrance at zero grade on the first floor, without steps, a first floor-accessible bathroom, and halls and doorways wide enough for a wheelchair."

"This design element is a simple courtesy that not only allows the elderly to age in place, but also makes it possible for a kid living there who, for instance, breaks his ankle, to get

around until he's better. And it also makes it easier for elderly and disabled individuals to visit or live in that home. This makes life so much easier for everyone, and is a much more elegant solution than installing wheelchair ramps or lifts."

"Business owners have to find ways to make their businesses more accessible – even for those businesses not covered by ADA because of the age of the building. A ramp shouldn't cost more than $200 to $500. Businesses are losing customers just because mobility-impaired people can't get in the front door. I can't take my mother to restaurants in Philadelphia because they're one step up from the pavement. Even a change as simple as not placing items on shelves that are 6 feet off the ground would make a business more elder-friendly."

Existing Facilities for the Elderly

"Many of Philadelphia's existing buildings for the elderly should be updated. There are serious design issues such as high rises with poor accessibility and no air conditioning. Also, a lot of buildings were designed with efficiency units, but most elderly people can't or won't live in efficiencies. That layout just doesn't work for someone who is an independent, free person. Efficiencies only make sense for people who have high service needs. There is a strong market in Philadelphia for subsidized one-bedroom apartments, but not for efficiencies."

"Existing elderly housing facilities are segregated by age. This is a dinosaur model. Elderly people don't like to be segregated by age. Old people benefit from living with a younger population. Likewise, younger people benefit from living near the elderly."

"If Section 8 housing vouchers are changed or eliminated, affordable housing may not be available. As a result, people may not be able to age in place."

"There is an enormous population in Philadelphia of older vulnerable adults who live in personal care boarding homes. These buildings have very bad regulatory oversight, are in shoddy physical condition and typically offer indifferent care. If the regulation and enforcement of these boarding homes is ever addressed in a meaningful way it would impact the city a lot. This is a big bunch of people (estimated at 10,000) who are not getting the quality services they should."

"Assisted living is as much real estate market driven as care driven. I don't see wider penetration even with an increase in the older population until assisted living providers look at the whole package and can price it down to the middle class affordably. Assisted living is over-built at the high end, and they didn't think it through on the care side."

Age Integration in Housing

"Age integration is a good thing because younger and middle-aged people are 'the helpers' of the older people. New York and Pittsburgh are pushing ahead on supporting Naturally Occurring Retirement Communities (NORCs) for this reason."

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"Systems need to move away from age delineation. There are 59 year old grandparents raising grandkids who can't get PCA services because they have to be 60. If a community is going to grow and be healthy and sustained, it needs to meet the needs of people as they move through the life course. Social service organizations need to support care-giving families as they care for younger members and older members, and have to intentionally foster interaction across age groups. Aging networks need to be proactive about facilitating social ties and creating opportunities for productivity, personal growth, learning, and civic engagement – for instance, by welcoming senior citizens into the schools to tutor children, and by offering computer classes to senior citizens at those schools, as well."

"I hope that ten years from now aging will always be on the table when we talk about neighborhood development. We need to prepare our young people to live in this aging society – to see this not as a strain but as an opportunity for older people to contribute to the community."

De-institutionalization

"I am skeptical of the concept that elderly people in nursing homes could and should live at home with services. We need to remember that people who live in nursing homes are basically homeless: they need bedding, furniture and everything else you would need to set up a house. Also, a high percentage of the elderly have dementia, which clearly is problematic in an isolated apartment. The most serious consideration, however, is the breadth of disability issues for the elderly. Their needs are complex, and the last thing most elderly individuals would want to do is call around to agencies to organize their own services."

"One possible solution is to have something called a 'LIFE Center,' a good service delivery organization that can coordinate and deliver services to elderly individuals living at home."

"There is a shift in attitude. You have to give former nursing home residents independence because there's just not money for anything else. People are going to be forced into accepting this but there is a lot of discomfort with this trend. Nobody wants to be an advocate for something that could be considered unsafe for this poor elderly person."

Integration of Services

"I believe that the housing provider and the service provider shouldn't be the same. But the opportunity to have services provided to you at home so you can stay independent and age in place is a wonderful thing. We need to build in the flexibility to let people have choice about their level of independence and at the same time assure they are safe and that there is adequate oversight."

"Nonprofit organizations are looking at expanding beyond nursing homes to develop at-home divisions that would offer assessment plus coordination and supply of medical and non-medical services."

"Philadelphia's aging service providers need to work with other groups to address the needs that are common to a particular geographic community in terms of caregiving for children, the disabled and the elderly. For example there are communities in Arizona where these types of groups are doing collaborative community assessments and mapping the resources they need and where they want to be in five years. Foundations are giving them money to move ahead with this. People are so excited because before everyone was going after the same money. By coming together they can achieve so much more. This is a life span approach to community-building that is very place-based and that makes it much easier for individuals to move through the life span. Philadelphia is a tough political climate but with some leadership this could happen here, as well."

Urban Versus Suburban Housing for Seniors

"There is going to be some kind of backlash against this idea of only building senior communities out in the suburbs in green fields with no sidewalks, no transportation and no services. Bring people back to where there's transportation, services, activities and things to do. There is going to be an increasing market for senior housing in the city."

"This opportunity is there but it hasn't gotten baked into forecasts in a quantitative way. Smart developers have started looking for opportunities. They are just now putting their toes in the water for some new residential projects in the city where there is an opportunity for senior housing. But the character and perception of the city needs to change so therefore this involves a large-scale investment."

"So far, senior housing has been more along the suburban model because that's what the developers know how to build. They ended up getting driven into building senior communities in the suburbs because the land is available, but communities don't want more school-age children due to property tax concerns. Then these developers build more suburban senior housing because it's a self-creating market. But those communities will not service seniors as they get older. There's no public transit, or cultural attractions, and not a significant enough level of support for those seniors as they get older."

"There's a whole marketing effort around college students, trying to attract more students to the Philadelphia region, trying to get them more involved within the city's culture and regional job market while they are here in order to get them to stay. While that doesn't have a direct impact on the senior population, it increases the overall sort of image of the city and quality of life. To the extent that Philadelphia's college town marketing takes off and is successful, I think we will attract more seniors into the city. The activities and culture offered by college towns explains why they are now doing so well as senior retirement communities."

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IV. D   Health and Disability

IV. D. 1   Introduction: Physical Health

> "To me, it's very important to have good health and to feel good." - Focus group participant

> "Now if you don't know how to manage… I'm telling you, the medical bills and all that… Put your pride under the table and go to the Health Center. I find they take very good care of me. They give me my medicine and everything. I've got one of the excellent doctors." - Focus group participant

> "I should be on this [medicine], but I don't take them because I can't afford to get them." - Focus group participant

> "I think my biggest fear is the shortage of home health aides that are trained properly…. I think it's tremendously lacking today with my friends who are just trying to secure daytime services while they work for their parents, who can't make it at the community service center now… There is a tremendous language barrier…" - Focus group participant

One of the most complex and important questions in the field of aging concerns the projected incidence of chronic health conditions and disability in future years. Will chronic health conditions and functional declines affect 65, 75, and 85 year olds at the same pace they do now, or will improvements in living standards and medical care reduce or postpone the onset of chronic illness and disability? The answers to these questions have important implications for the need and cost of future institutional and community-based long-term care services.

This section reviews national trends in disability rates and whether these trends might or might not be relevant to Philadelphia. It also provides national projections and retrospective trend analysis for selected chronic health conditions that typically reduce the quality of life and functional independence for elders.

Although national trends provide useful general guidelines for planning, they cannot be applied directly to forecast rates of disability in Philadelphia's future older population. This is because the city's seniors may differ in important ways from the national profile – particularly in characteristics statistically linked to poor health status and disability such as age, gender, ethnicity and income, which are powerful predictors of functional decline.

Collectively, these factors cannot be seen as predictive, but they do suggest that in the future Philadelphia's elderly population will be statistically more likely than their peers nationwide to experience health difficulties and disabilities for the following reasons:

- Age is a strong predictor of need for long-term care services. Over the next 10 years, Philadelphia expects a 10% rise in its 85+ population. The number of

Pennsylvania residents 85 and older is expected to increase by more that 50% from 2000 to 2010.

Persons age 85+ will comprise 2% of the US population in 2015, an increase of 29%.

- Disability also occurs statistically at a higher rate among people living in poverty. (Finnish Center for Interdisciplinary Gerontology, 2004) A higher percentage of Philadelphia's elderly live in poverty than do the elderly in the state of Pennsylvania and nationally.

- Retrospective data nationally suggests there is a higher incidence of disability among non-white populations. (Hall, 1993; Johnson et al, 2002) The trend toward non-Caucasian-majority status in Philadelphia will intensify by 2015.

IV. D. 2   National Trends in Elderly Health and Disability

Research is emerging regarding anticipated future disability levels among the elderly nationally. But divergent data has so far undermined researchers' ability to make conclusive predictions. (Redfoot and Pandya, 2002) For instance, nationally the demand for long-term supportive and medical services is not expected to increase substantially until well into the 2020s when the oldest members of the postwar generation begin to turn 75, according to AARP. (Redfoot and Pandya, 2002) There may be a different and earlier dynamic of increasing need in Philadelphia due to the city's shift toward an older, less affluent population.

But at the same time, most analysts report that disability rates have declined among the elderly nationwide and anticipate continued declines over the next 10 to 30 years. Health care researchers don't fully understand the reasons or the impact of this trend on various subgroups of elderly. In particular, it is not clear at all that such changes will be found among poorer older adults. Experts vary in the rates of decline they project for the future, and have not yet defined whether or how this anticipated decline would affect particular demographic subgroups of the elderly differently. (Spillman, 2004; Redfoot and Pandya, 2002)

One difficulty in forecasting aggregated need for long-term care services, both locally and nationally, comes from the question of whether the size of the aging postwar generation might offset projected declines in the total population of elderly individuals with chronic disabilities. In addition to the challenge of forecasting the need for long-term care, it is difficult to determine the distribution of numbers anticipated in the many different settings in which care will be delivered in the future.

A recent AARP report, *Beyond the Baby Boom*, examines three scenarios for disability rates, based on an analysis of the National Long-Term Care Survey (Manton et al):

- Disability rates remain constant at the 1994 level.

- Disability rates decline at the 1989 to 1994 rate (1.5% per year compounded).

- Disability rates decline at the 1994 to 1999 rate (2.6% per year compounded).

These divergent rates yield widely differing projections for the number of disabled older adults in the nation over the next 20 years or more. Taking these three scenarios into account, the range of elderly individuals nationally with disabilities would be 6 million to 9 million in 2010, and 6 to 16 million in 2030. (Redfoot and Pandya, 2002)

Researchers are investigating causes for the declines in chronic disabilities and their divergent effects on different groups of older people. Declines might reflect improved standards of living and medical care as well as the increased availability of assistive devices and other technology to enhance independent living. A number of national studies have found that declines in disability are more apparent in instrumental activities of daily living (IADL) than in activities of daily living (ADL). IADLs are typically defined as light housework, laundry, meal preparation, grocery shopping, getting around outside, taking medications, managing money and using the telephone. ADLs typically are defined as eating, getting in and out of bed, getting around inside, bathing, dressing, and toileting. Some research indicates that better educated seniors may experience greater reductions in levels of disability. (Redfoot and Pandya, 2002)

Data for elderly low-income individuals, in particular, suggest that the overall projected growth of this population will outpace anticipated declines in chronic disabilities. This would yield a dramatic rise in the population of low income elderly individuals with chronic disabilities. The Commission on Affordable Housing and Health Facility Needs for Seniors into the 21st Century report, *A Quiet Crisis in America*, projects disability rates among people age 65 and up whose incomes are within 150% of federal poverty guidelines. Despite a projected declining disability rate (a 1% annual decline for 1997-2000 and a 0.1% decrease every five years thereafter through 2020), this report anticipates a rapid growth in the number of low-income elderly with long-term disabilities, particularly in the 10 years ending 2020, as shown in the table below.

Figure 30: Functional Limitation Forecast for U.S. Elderly 2000-2020

Functional Limitation Forecast for U.S. Elderly 2000-2020					
Type of Disability	**2000**	**2010**	**2020**	**% Change 2000-2010**	**% Change 2010-2020**
Total # below 150% poverty	8,603,591	9,636,990	12,952,292	+12.0	+34.4
No ADL/IADL disabilities	6,189,880	7,090,412	9,861,142	+14.5	+39.1
At least one IADL disability	1,371,834	1,440,181	1,755,068	+5.0	+21.9
At least one ADL disability	1,041,878	1,106,396	1,336,081	+6.2	+20.8
With a mental disability	1,002,988	1,059,319	1,307,688	+5.6	+23.4

Source: Commission on Affordable Housing and Health Facility Needs of the Elderly into the 21st Century, 2002

The national disability rates projected in the table may be relevant to Philadelphia's current and future demographic profile. In the next 10 years and beyond, the city will have a rapidly growing number of very old (85+) residents, as well as rising numbers of non-Caucasian elderly, many living on low incomes. These factors are closely associated with functional decline.

Nationally there will be steady growth among indigent elderly individuals facing functional limitations in the decade spanning 2000-2010; and this growth will accelerate in the decade from 2010-2020. The number of indigent elderly individuals facing at least one limitation in Activities of Daily Living (defined as needing at least some help with: eating, dressing, grooming, walking, getting in/out of bed, bathing and toileting) will grow 6.2% from 2000 to 2010, and will rise again by 20.8% between 2010 and 2020.

Similarly, the number of elderly indigent individuals who will face limitations in Instrumental Activities of Daily Living (defined as needing at least some help with using the phone, getting to places out of walking distance, shopping, cooking, housework, taking medicine and money management) will grow 5% between 2000 and 2010, and will rise another 21.9% between 2010 and 2020. ADL deficits represent more significant functional declines than IADL limitations and occur in addition to IADL restrictions.

On a more positive note, the number of elderly indigent individuals who are expected to have no disabilities in ADL or IADL is also projected to rise 14.5% between 2000 and 2010, and another 39.1% between 2010 and 2020.

IV. D. 3   Past Indicators of Disability Onset Among Philadelphia's Elderly

"I'm 65 years old, I have diabetes, I have cancer, and I have heart problems." - Focus group participant

"I've started exercising because I've realized that me being overweight is going to be a big factor in my health. I got into an exercise program though one of the drug companies and I'm working on that to help lower my blood pressure and help with my asthma." - Focus group participant

This section of the report provides retrospective data for several leading chronic, disabling health problems experienced by Philadelphia seniors. According to Older Americans 2004, these three conditions – heart disease, cancer and diabetes – were among the leading causes of mortality among the elderly in the period from 1981 to 2001. These data were obtained from individuals ages 60+ contacted for the Philadelphia Health Management Corporation's (PHMC) household health survey, which is conducted every two years. This section reports on findings related to health conditions for Philadelphia elders only.

PHMC (2002) inquired about six common health problems and found the incidence of these conditions to be:
- Arthritis (59%);
- Heart condition (26%);
- Allergies (25%);
- Diabetes (19%);
- Asthma (9%);
- Cancer (6%).

In some cases, data from the PHMC household survey are presented in terms of three age groups – those age 65 to 74 years old, those age 75 to 84 and those age 85 and above – but, in other cases, just two age groups are mentioned, age 65 to 74 and 75+. This occurs where the number of respondents in the 85+ category was too small to be analyzed separately.

PHMC's survey data cannot be used to make predictions about specific, future physical and mental health outcomes for Philadelphia's elderly population. Given earlier predictions regarding the expected age, race and income structure of Philadelphia's elderly population, one can assume that current levels of chronic illness and disability are not likely to decline dramatically in the next two decades. Chronic health conditions among the elderly are expected to remain a significant force affecting the medical and functional needs of elderly Philadelphians. Where relevant, PHMC's household survey data for representative chronic health conditions is supplemented with selected national and statewide data to identify possible future scenarios.

In the 2002 PHMC survey, 36% of all individuals surveyed reported having one or more IADL limitations and 19% reported one or more ADL limitations. Advancing age is directly correlated to increased disability in the PHMC's data. One or more ADL limitation was reported in 2002 by:

- 11% of seniors age 65 to 74;

- 23% of respondents age 75 to 84;

- 39% of individuals age 85+.

One or more IADL limitation was reported by:

- 25% of seniors age 65 to 74;

- 41% of respondents age 75 to 84;

- 72% of individuals age 85+.

Representative Chronic Health Conditions among Philadelphia's Elderly

Allergies

Allergies are not an age-related chronic condition. However, allergy-related problems can potentially compound difficulties with related life realms such as housing, home maintenance, self-care, and prescription formulation.

Overall, during the eight year period of 1994 to 2002, the proportion of older people with allergies rose from 23% to 28%, a statistically significant increase. The young-old (those age 60-64) and women were statistically more likely to report having allergies than other groups.

In the PHMC's household survey, the incidence of reported allergies is highest (32%) among the population of individuals age 60-64 in 2002. This age cohort is the leading

edge of the large postwar generation. This group represents a larger population of elderly individuals who will cope with allergies in addition to the typical chronic conditions associated with old age. A slightly larger portion of the postwar cohort who will be age 50-59 in 2002 (33%) reported allergies in the PHMC survey.

Among women over 60 in the sample, 26% reported experiencing allergies in 1994, rising to 31% in 2002. By comparison, 18% of men reported allergies in 1994, rising to 22% in 2002. Additionally, the incidence of allergies reported by non-Caucasians was slightly higher (25% in 1994, rising to 31% in 2002) than was reported by Caucasians (23% in 1994, rising to 27% in 2002).

Figure 31: Allergy Incidence among Elderly Philadelphians

Allergy Incidence among Elderly Philadelphians Percent Experiencing Allergies (by Year)					
	1994 (%)	1996 (%)	1998 (%)	2000 (%)	2002 (%)
By Age Group					
Total – Age 60+	23	21	22	24	28
Age 60-64	25	22	29	27	32
Age 65-74	24	21	22	24	28
Age 75+	20	19	19	21	25
Gender					
Men	18	15	17	17	22
Women	26	24	25	27	31
By Race					
Caucasians	23	21	22	23	27
Non-Caucasians	25	23	25	26	31

Source: PHMC Household Surveys 1994, 1996, 1998, 2000, 2002

Arthritis

"The big thing for me that's changing is that I don't shop for myself as much as I used to because I'm starting to get arthritis. It's making a big difference in things I can do. It could be cooking, picking up frying pans, lifting bags, different things like that. I'm getting arthritis in my knees, my hands, my elbows. You know -- I feel like I'm falling apart [laughter]. And I don't consider myself a senior. I'm 51. I think in the next five years, if my arthritis keeps getting bad, I know I'm going to need somebody to help me shop, help me clean, you know. And I still won't be near 70. As bad as it's getting now, I need some assistance with just everyday things." - Focus group participant

Many limitations in activities of daily life can be attributed to arthritis or chronic joint symptoms (CJS). In fact, arthritis is said to be the leading cause of disability in the U.S., and the leading cause of activity limitation among the elderly. (Seitchik, 2003)

In Philadelphia between 1994 and 2002, the number of individuals ages 60+ reporting arthritis rose from 45% to 52%. Not surprisingly, there is a significantly higher

percentage of arthritis cases among the older old (58% of individuals age 75+) than among the younger groups (41% of individuals age 60-64).

PHMC's data on the incidence of arthritis in Philadelphia was also heavily weighted by gender – which parallels state and national arthritis data. A significantly higher percentage of women respondents reported arthritis (52% in 1994, rising to 57% in 2002) than men (33% in 1994, rising to 43% in 2002).

The experience of arthritis is also weighted significantly by ethnicity. Lower rates were reported among Caucasians (44% in 1994, rising to 50% in 2002) than by all other ethnic groups (50% in 1994, rising to 57% in 2002).

Figure 32: Arthritis Incidence among Elderly Philadelphians

Arthritis Incidence among Elderly Philadelphians Percent Experiencing Arthritis (by Year)					
	1994 (%)	**1996 (%)**	**1998 (%)**	**2000 (%)**	**2002 (%)**
By Age Group					
Total – Age 60+	45	44	48	50	52
Age 60-64	38	35	37	43	41
Age 65-74	45	45	46	49	53
Age 75+	55	51	56	55	58
Gender					
Men	33	32	36	36	43
Women	52	50	54	57	57
By Race					
Caucasians	44	41	46	47	50
Non-Caucasians	50	52	54	58	57

Source: PHMC Household Surveys 1994, 1996, 1998, 2000, 2002

By comparison, national data from *Older Americans 2004* show that a relatively stable percentage of people age 65 and older had arthritic symptoms during the period from 1997-1998 (37%) through 2000-2001 (36%). Nationally in 2000-2001, more women (39%) than men (31%) were affected by arthritis. Approximately 70% of Pennsylvanians 65 years and older have arthritis, of which the majority (two-thirds) are women. (Seitchik, 2003) The number of older Pennsylvanians with arthritis is projected to increase by 42 % by 2020. The table below shows projections from 2005 to 2025.

Figure 33: Pennsylvania Population with Arthritis / Chronic Joint Symptoms (CJS)

Pennsylvania Population Aged 65 and Older with Arthritis / Chronic Joint Symptoms (CJS) Projected for 2005 to 2025			
Year	**Number (in thousands)**	**% PA population**	**Number with Arthritis or CJS (in thousands)**
2005	1,867	15.2	1,320
2015	2,092	16.8	1,476
2025	2,659	21.0	1,872

Source: Seitchik, 2003

Asthma

The absolute number of elderly asthma sufferers, another chronic health condition, is also expected to increase in future years. Again, asthma is not age-related, but it does complicate experiences with housing, home maintenance, self-care, and prescription formulation. It can also be interpreted as a reaction to a polluted environment.

The reported incidence of asthma in the PHMC sample grew slightly overall from 5% to 8% of the total population in the period from 1994 to 2002. Among individuals age 60 to 64, 8% experienced asthma in 1994, growing to 10% by 2002. Similar increases occurred among individuals age 65-74 – from 4% in 1994 to 9% in 2002. Among individuals age 75+, the incidence of asthma rose from 4% in 1994 to 7% in 2002.

Slight differences in the experience of asthma by gender and ethnicity emerged in the survey. In 1994, 4% of men and 6% of women surveyed experienced asthma, rising in 2002 to 7% of men and 9% of women. In 1994, 5% of Caucasians and 8% of other ethnic groups surveyed experienced asthma, rising in 2002 to 7% of Caucasians and 11% of other ethnic groups.

Figure 34: Asthma Incidence among Elderly Philadelphians

Asthma Incidence among Elderly Philadelphians Percent Experiencing Asthma (by Year)					
	1994 (%)	**1996 (%)**	**1998 (%)**	**2000 (%)**	**2002 (%)**
By Age Group					
Total – Age 60+	5	6	5	5	8
Age 60-64	8	7	6	6	10
Age 65-74	4	6	5	5	9
Age 75+	4	5	5	5	7
Gender					
Men	4	5	4	5	7
Women	6	7	6	6	9
By Race					
Caucasians	5	5	5	5	7
Non-Caucasians	8	8	8	8	11

Source: PHMC Household Surveys 1994, 1996, 1998, 2000, 2002

Older Americans 2004 reports that, in 2001-2002, 8.4% of people age 65 or older nationally had asthma, with 9.2% of women and 7.3% of men reporting the condition. These percentages are similar to the PHMC findings. A slightly higher percentage of African Americans (9.1%) reported having asthma than whites (8.3%) and Hispanics (8.1%).

Cancer

Trends in reported cancer in Philadelphia over time are unclear. Incidence appeared to decline in the 1990s but increased again by 2002. A slightly greater percentage of men than women were affected by cancer in each of the years studied: 6% of men compared to

4% of women in 1994, rising in 2002 to 7% of men and 5% of women. A slightly greater percentage of Caucasians surveyed were affected by cancer overall, 5% in 1994 and 6% in 2002, while the incidence of cancer among all other ethnic groups remained stable at 4%.

By comparison, national data from *Older Americans 2004*, showed that in 2001-2002, almost 21% of people age 65+ had cancer, up from 18.7% in 1997-1998. Nationally, a greater percentage of men than women were affected by cancer – 24.5% of men age 65+ compared to 17.9% of women age 65+. It is possible that the proportion of elderly Philadelphians reporting a cancer diagnosis in the PHMC study is lower than the national rate because of an under-count; that is, older people with cancer may not have had the stamina to participate in the PHMC interview, or may be unaware of their diagnosis.

Figure 35: Cancer Incidence among Elderly Philadelphians

Cancer Incidence among Elderly Philadelphians Percent Experiencing Cancer (by Year)					
	1994 (%)	**1996 (%)**	**1998 (%)**	**2000 (%)**	**2002 (%)**
By Age Group					
Total – Age 60+	5	4	3	4	6
Age 60-64	4	3	3	4	4
Age 65-74	5	4	3	4	6
Age 75+	5	4	3	5	6
Gender					
Men	6	6	4	6	7
Women	4	2	3	4	5
By Race					
Caucasians	5	4	3	5	6
Non-Caucasians	4	3	3	3	4

Source: PHMC Household Surveys 1994, 1996, 1998, 2000, 2002

Diabetes

In Philadelphia, the proportion of elderly individuals with diabetes grew steadily among all individuals ages 60+, from 12% in 1994 to 17% in 2002. The rise in reported incidence was the same among individuals 60-64 and among individuals 65-74 (from 13% among both age groups in 1994 to 17% among both age groups in 2002). The greatest increases in diabetes occurred among individuals age 75 and up: rising from 10% in 1994 to 17% in 2002. Males and females experienced diabetes at similar rates in 1994 (12% for both men and women). However, by 2002, diabetes was reported by a significantly higher percentage of men (20%) than women (15%).

PHMC's retrospective data for diabetes also show significant differences between Caucasians and all other groups. The incidence of diabetes among Caucasian elders grew from 10% to 14% between 1994 and 2002. The incidence of diabetes among all non-Caucasian seniors started at 20% among this population in 1994, double the percentage of Caucasians reporting diabetes that year, and grew to 27% of in 2002.

According to national data from *Older Americans 2004*, 15.5% of people age 65+ had diabetes in 2001-2002, up from 13% in 1997-1998 – with more men (18%) than women (14%) affected. National data for individuals ages 65+ shows that in 2000-2001 incidence of diabetes occurred among 14% of Caucasians and 23% of African Americans and Hispanics.

Figure 36: Diabetes Incidence among Elderly Philadelphians

Diabetes Incidence among Elderly Philadelphians Percent Experiencing Diabetes (by Year)					
By Age Group	**1994 (%)**	**1996 (%)**	**1998 (%)**	**2000 (%)**	**2002 (%)**
Total – Age 60+	12	14	15	16	17
Age 60-64	13	11	13	17	17
Age 65-74	13	16	16	18	17
Age 75+	10	14	14	14	17
Gender					
Men	12	13	14	18	20
Women	12	15	15	16	15
By Race					
Caucasians	10	12	13	13	14
Non-Caucasians	20	23	23	26	27

**Source:** PHMC Household Surveys 1994, 1996, 1998, 2000, 2002

Obesity

> "I've also started exercising because I've realized that me being overweight for my height is also going to be a big factor in my health. So, I actually got into a exercise program through one of the drug companies and I'm working on that so that would help lower my blood pressure, that would help with my asthma. It's not helping much with my arthritis but at least, you know, if I lose some of the weight, at least the blood pressure and asthma will kind of take care of themselves." – Focus group participant

Obesity can be correlated with diabetes, as well as heart disease, hypertension and orthopedic problems. PHMC data for Philadelphia for 2002 indicates that 35.8% of individuals ages 60-74 say they are obese compared to 18.6% of individuals age 75 and older. The PHMC also generated self-reported data on diet: in 2002, 74.1% of white and 66.9% of minority elders said they have at least two servings of fruits and vegetables per day.

The figure below shows obesity rates among various age groups in Pennsylvania. It demonstrates that obesity is a rising problem among Pennsylvanians age 65 and above. In 1990, just over 10% of individuals ages 65+ reported obesity, climbing to nearly one-fourth of individuals age 65+ reporting obesity in 2002.

Figure 37: Obesity: By Body Mass Index
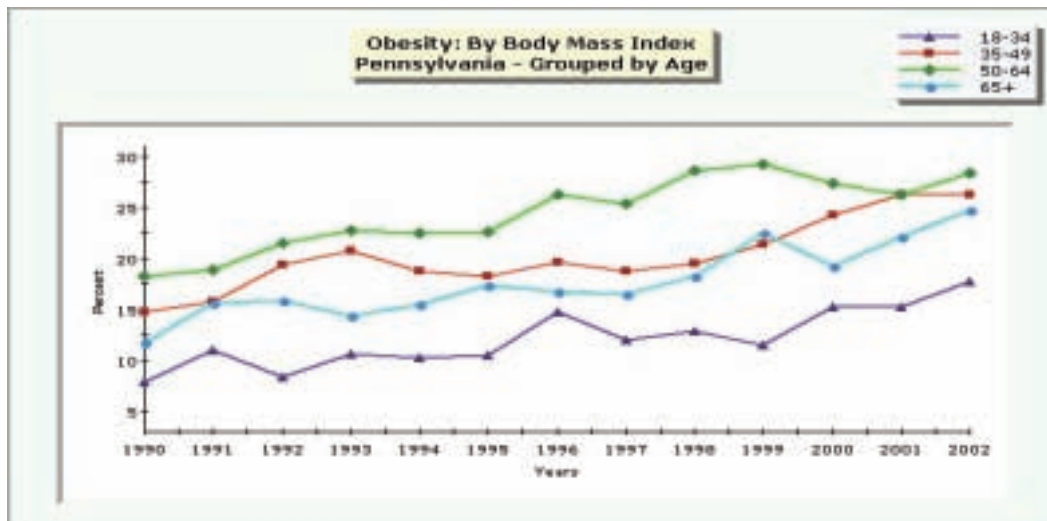
Nationally, the prevalence of obesity among individuals age 65+ has increased from 22.26% in 1988-1994 to 29.8% in 1999-2000, according to *Older Americans 2004*. More women than men age 65 and over are obese (32% versus 26.5%).

Cardiovascular Disease

"I have to take heart medicine every day, have to take it for the rest of my life; and it's very expensive medicine. And if my husband stops working soon, I'm not old enough to go to Medicare…. I won't have anything. But I still have to have my medicine every day. It's $125 every two weeks for medicine." - Focus group participant

From 1994 to 2002, the incidence of reported heart conditions rose slightly from 21% to 23% among all PHMC respondents age 60 and up. *Older Americans 2004* reports that nationally 31.2% of 65+ year olds had heart disease in 2001-2002 (down slightly from 32.3% in 1997-1998).

The incidence of reported heart conditions is strongly correlated with age, occurring in greater numbers among each successively older group (16% of 60-64 year olds compared to 31% of individuals 75+ in 2002). However, the incidence of reported heart conditions within each age group remained relatively stable between 1994 and 2002. Incidence of heart conditions remained unchanged among individuals age 60-64 (16% in 1994 and 2002), declined slightly among individuals ages 65-74 (20% in 1994 and 19% in 2002), and grew slightly among individuals ages 75+ (29% in 1994 to 31% in 2002).

Based on the PHMC survey, more male respondents (24% in 1994 and 28% in 2002) reported heart conditions than female respondents (19% in 1994 and 20% in 2002). Among Caucasians, reported heart conditions increased from 20% of respondents in 1994

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to 23% in 2002. Among all other ethnic groups, the incidence of reported heart conditions declined slightly from 23% of respondents in 1994 to 21% in 2002.

Similar trends for gender and ethnicity held true nationally as well. According to *Older Americans 2004*, in 2001-2002, heart disease was reported by nearly 37% of men and 27% of women ages 65+. Differences emerged by ethnic identity as well, with an incidence of heart disease among individuals ages 65+ in 2001-2002 reported by 32% of whites, 26% of blacks, and 22% of Hispanics.

Figure 38: Percent of Elderly Philadelphians Reporting Heart Conditions (by Year)

Percent of Elderly Philadelphians Reporting Heart Conditions (by Year)					
	1994 (%)	1996 (%)	1998 (%)	2000 (%)	2002 (%)
By Age Group					
Total – Age 60+	21	18	20	22	23
Age 60-64	16	13	13	14	16
Age 65-74	20	17	19	21	19
Age 75+	29	25	27	27	31
Gender					
Men	24	20	22	25	28
Women	19	17	20	20	20
By Race					
Caucasians	20	18	19	21	23
Non-Caucasians	23	20	23	24	21

Source: PHMC Household Surveys 1994, 1996, 1998, 2000, 2002

Visual and Hearing Impairments

Both vision and hearing impairments pose considerable safety risks for the elderly, and can have a spill-over effect, limiting activities of daily life and contributing to depression. Loss of vision and hearing is directly correlated with age – a fact clearly illustrated by data from the 2000 IPUMS: just 5% of individuals ages 50 to 59 reported hearing or vision difficulty compared to 29% of individuals age 85+.

Looking at the numbers specifically for visual impairment, Dr. Elaine Gerber from the American Foundation for the Blind estimated that, based on U.S. Census 2000 data, by the year 2015, there will be nearly 23,000 individuals ages 65+ in Philadelphia with visual impairment. This represents a 17% increase over the 2000 estimate of 19,528 individuals age 65+ with vision impairment in Philadelphia. However, due to differences in how blindness is defined and identified, these estimates may differ from other statewide or national projections.

In the IPUMS, data for blindness and hearing impairment (which is also difficult to define consistently) are bundled together. In this sample, 12% of Philadelphians age 65+ reported a hearing or vision impairment in 2000. The effects by age are evident: 6.9% of adults age 65 to 74, 18.5% of those ages 75 to 84, and 29.2% of those 85+ reported a vision or hearing impairment.

According to *Older Americans 2004*, 37.2% of Americans age 65 and over report having trouble hearing, and 17.5% report trouble seeing. Men (47%) are more likely than women (30%) to report hearing problems, but women (19%) are more likely than men (15.6%) to report vision trouble. The effects of age are apparent nationally as well, with 60% of those age 85 or above reporting hearing problems and 33% reporting vision problems.

HIV/AIDS

According to the *Merck Manual of Geriatrics*, nearly 10% of all people diagnosed with HIV/AIDS in the U.S. are 50 and older and 3% of all HIV/AIDS cases in the U.S. are 60 and older. (Merck, 2004) The National Institute on Aging estimates that there are nearly 75,000 individuals with HIV/AIDS ages 50 and up in the U.S. This could be an under-reported trend, both locally and nationally: older people are not typically tested for HIV/AIDS on a regular basis due to the prevailing myth that they are no longer sexually active.

Most elderly persons who are sexually active do not perceive themselves as being at risk of HIV infection. They are one-sixth as likely as persons in their 20s to use condoms during intercourse. (Merck, 2004) Health care agencies need to counsel older patients in safe sex practices – particularly since treatment and medication for sexual dysfunction may enable some older adults to increase their sexual activity. Heterosexual women of all ages are one of the fastest growing groups of AIDS patients nationwide; this trend is similarly observed in the older female population nationally. (Kaiser Family Foundation, 2000)

For those elderly people who are diagnosed with HIV/AIDS, the diagnosis is complicated by social stigma and complexities associated with anti-viral therapies such as interactions with other drugs and medication side-effects. Some anti-viral drugs have side effects that are similar to conditions in an aging population – Type 2 diabetes, osteoporosis and high cholesterol – but these conditions appear 20 years earlier than in the general population. (UPI, 2002) Additionally, HIV-associated dementia usually occurs in the later stages of AIDS, and is the presenting condition in 10% of all cases. (Merck, 2004)

Data from the Kaiser Family Foundation for all new cases diagnosed nationally and in Pennsylvania in 2003, show that Pennsylvania's incidence rate for AIDS for whites matches national trends. However, African Americans in Pennsylvania have a higher incidence rate than nationally (53% compared to 48%). Hispanics in Pennsylvania have a lower incidence rate than nationally (13% compared to 18.5%).

Figure 39: Distribution of New AIDS Cases by Race/Ethnicity – All Ages

Distribution of New AIDS Cases by Race/Ethnicity – All Ages Nationally and in Pennsylvania in 2003		
Ethnic groups	Pennsylvania (%)	United States (%)
Caucasian	32.5	31.1
African American	52.9	48.9
Hispanic	13.2	18.5
Asian / Pacific Islander	0.9	1.3
American Indian /Alaska Native	0.1	0.5

Source: Kaiser Family Foundation, 2005

Given the projected growth in Philadelphia's minority populations of 60+ individuals between 2005 (12%) and 2015 (49%), this may be an indication that the number of AIDS cases among these population groups may increase. However, this would only be true if lack of prevention and risky sexual and drug abuse behaviors persist.

Data from the Center for Disease Control for 1999 indicated there were approximately 167 AIDS cases among the 65+ population in Philadelphia. (Fallik, 2003) There are an estimated 6,145 persons over the age of 45 in Philadelphia who are living with HIV/AIDS, according to Dr. Kathleen Brady, of the AIDS Activities Coordinating Office in Philadelphia.

Focus Group Participant Views of Health Care

Not surprisingly, focus group participants cite need for health care as one of their major concerns. They indicate that health – both physical and mental health – is the cornerstone of their ability to enjoy good quality of life. Although they are interested in taking preventive health measures, some feel thwarted when health insurance does not cover fitness programs, home modification and other strategies. Overall, focus group members believe that government and/or the health care industry – not individuals and families -- should be responsible for the cost of health and social service programs for older adults.

Private long-term care insurance is seen as too expensive; in fact, only one focus group member had purchased it. Focus group participants worry that American culture devalues the elderly, disabled and sick, which can lead to dehumanizing care. A special consideration is the need for sensitive, well-trained home health aides, who communicate well and show compassion and respect for those in their care.

Insights from Community Leaders

Prospects are unclear for the future health care needs of Philadelphia's elderly, the future of health care and malpractice reform, and potential changes in the economics of health care. However, changes in these dynamics as well as the current trend toward community-based care all merit careful consideration by local agencies serving the elderly.

Community leaders also point to a complex array of economic and political dynamics that are undermining the morale and numbers of people who work with the elderly. This labor force shortage seems to apply consistently across the medical, social work, nursing, and mental health professions – as well as to the leadership of organizations that serve the elderly.

Discussions with community leaders included a wide range of viewpoints on these and related trends, as seen in the quotes below.

Realigning the Health Care System

"How the problems of the aging are solved will be affected by other huge factors. In health care, we face enormous challenges. We are under financial stress. We have growing numbers of uninsured people, an aging population with greater needs for care, and workforce shortages that leave us with fewer people to provide care."

"A big problem is that our health care system evolved since the 1940s and 1950s primarily to take care of episodes of acute illness. Hospitals and doctors are good at that, but technology has given us the ability to enhance the length and quality of life. We need to move to a system that can handle people with multiple chronic conditions. Today, we don't have the people or mechanisms to do this well."

"The whole model of health care needs to progress over the next decade. We need to build the capability to provide comprehensive care."

Who Will Pay?

"Do we have the political will to assure healthcare for everyone? How can we do this when some are uninsured now?"

"Is longevity a family's burden or the taxpayer's burden?"

"We believe that services should follow the individual, not the other way around. But this raises important questions: How will we do that? How will we pay for it? What will we ask people to contribute? That is a mind-boggling proposition right now."

"In order for people to maintain their independence, they need medical coverage for prescription drugs, tests, rehabilitation and other services. People need money to maintain their health."

Projecting Future Needs

"Until 2015 and 8 to 10 years beyond, the demand for long-term care services will remain relatively constant."

"The need for medical services may remain relatively stable for the next 10 years. The younger age cohorts are growing, and the 75 to 84 year old group has a significant illness burden but is decreasing."

"What is the morbidity rate? How well will we live and how quickly will we crash and need services? Will we live healthier, use services for less time and, therefore, have a shift in chronic care cost? If baby boomers have just 10 percent less contact with the long-term care system, that would mean a big change."

"The future of long-term care is more related to the economy than services. Where the baby boomers will receive long-term care depends on the strength of the economy, and the strength of 401(k) and retirement plans. These factors will determine whether baby boomers with long-term care needs can afford to live independently at home."

"Will aging baby boomers have unrealistic expectations of medicine? Will they think they can make poor lifestyle choices, and then medicine will fix whatever ails them?"

Medicare and Medicaid

"In the next ten years as the population grays and becomes poorer, we are going to be even more reliant on the Medicaid dollar."

"We should have a single payer health care system so that we don't continue shifting costs from Medicare to Medicaid and vice versa. We should look at what makes sense for the patient, and everyone who is paying for health care."

"Integration of Medicare and Medicaid should be inevitable but I don't know if it will happen. There is no benefit to consumers in having two separate systems. That's why PACE[1] is a good thing. Maybe in 10 to 15 years, government will wake up and find that integration is better."

HMOs and Long-Term Care Insurance

"The term 'managed care' has become synonymous with heavy handed insurance practices that limit people's choices. The public reacted very negatively to that approach in the 1990s; and it is unlikely that we will go back to that model. However, coordinating care is absolutely essential. What might work are insurance products where consumers select their network of providers, as well as health savings accounts and related models. These approaches may generate more patient and family demand for data and accountability, all of which are good things."

"I'd like to say that long-term care insurance will be a factor, but it probably won't be in the next 10 years. There won't be significant market penetration until it becomes a group product and more affordable."

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[1] PACE is *Program of All-Inclusive Care for the Elderly.*

Shifting from Institutional to Community-Based Care

"The move to more in-home care can be seen as a grand social experiment on what will be cheaper. The government has a sense that in-home care may be cheaper than institutionalization, although some do not believe that is true."

"The shift is money driven. Guess what? You are going to give clients independence because there's no money for anything else. People are being forced into accepting it but there is a lot of discomfort. The pressures for home and community-based services are staggering. The move toward in-home care is driven by funding and autonomy issues."

"We need to support alternatives to institutional living for frail seniors and support caregivers. That has tremendous social benefit. The shift away from an institutional bias to home care is positive. That is where people want to be. Many kinds of care are more portable now and can be done at home, instead of in acute-care or residential facilities."

"Advances in technology and medicine will help us continue to look for the least expensive, most appropriate setting to care for people. The changes already are dramatic. Today's ICU patients would have died 20 years ago. Today's medical-surgical patient might have been in the ICU 20 years ago. Patients who needed medical-surgical care back then are now treated in nursing homes, and the 1980s nursing home resident now can be cared for at home."

"The shift to community-based care will increase significantly over the next 10 years. That's where the business should go. People will shift away from nursing facilities and opt for community care based on the degree to which housing and some social support are available. On the community-based side, we may not see a significant alteration in the types of services. We have a list of what's needed to cover a person now, although maybe we'll see a new thing or two."

"Right now, if you are older, on Medicaid, and need long-term care services, the presumption is for you to move into a nursing home. It's easy. The system is set up that way; and the nursing home industry loves it. In order to get community-based services, you have to go through the waiver process, which is a complicated paper trail. We hope to turn that around and presume that you can continue living in the community independently with the home-based services you need. The waiver should be for the nursing home because it is more expensive and restrictive."

"Nursing facilities will continue to lose market share. This trend will accelerate as the baby boomers move closer to retirement. Baby boomers will not accept semi-private rooms and rigidity. Independent nursing homes eventually will come around to integrating horizontally and developing community-based care subsidiaries."

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Consumer-Directed Care

"I'm not sure whether the money following the person works well and for whom. I'm concerned that we'll go overboard on aging in place, and not have a safety net for those who need it. There is a lot of discussion right now about safety. I think people are willing to accept what consumers want so long as it is safe in everyone's mind."

"Will it be good for consumers to have a more direct interest in how they use the health care system and what resources they choose? If services are a consumer commodity, it may be more difficult to coordinate care. Will the incentives discourage people from spending money or benefits on primary care and preventive services? Will that result in more complicated acute care episodes later? Will the incentives go the other way? It is difficult to predict how all that will play out."

"The shift to home and community-based care is a good, very important trend. However, it raises the question: Who decides what services each person should get? How do we protect consumers? How can consumers contest the service packages they are assigned? This is a new area and a challenge for agencies and consumers."

"There is a paradigm shift from nursing home to community. The younger disabilities community says to us, 'Who cares if you think I'm safe or not. I have capacity, and this is where I want to be.' They want the aging system network to shed its paternalistic views and work hard to promote consumer choice. I think we are doing it better than ever but we have a long way to go. As we move more services into the community, the quality assurance and review processes need to be in place."

"We need to reorient our tolerance for risk and how that interacts with self-determination. We need to find the mechanisms that enable people to assume risks and stay in the community."

"Individual choice will be more and more significant. This means a whole shift in thinking and we are not there yet. Agencies will need to accommodate what clients say they really want, instead of making choices for them based on assumptions."

"People with disabilities should be involved in shaping and directing their own care. Once they learn to direct their own services, they like it, young and old. Some of the older consumers are the savviest and toughest."

"We are shifting responsibility for choosing services from the government to consumers, but we haven't prepared consumers."

"The American concept that individual rights are paramount is built into our laws. In-home care reflects what some may see as a move to more autonomy for the elderly."

Interdisciplinary Teams, Pooled Funding and Information Technology

"Any chronically ill or physically impaired population does best when there is pooled funding because medical, social, spiritual, mental health and emotional issues all need to be addressed in a coordinated way. When different departments deal with different parts of the person, it's hard for the consumer and the providers."

"We need to find ways to implement interdisciplinary treatment teams and translate research into practice."

"We need to restructure the delivery system to manage people with multiple conditions and providers. This involves a large investment in information technology. Electronic health records are starting to be disseminated. This allows links with the Web and the set-up of patient health care protocols."

"A good example of interdisciplinary team-based care is the PACE model in Philadelphia. Generally, however, this type of approach is not supported by funding."

Health Promotion and Health Education

"We need new models of care in which healthcare providers partner with patients and the community to speak to health, not just to address disease. We need a health promotion and health education model. This involves creating a physical, social and policy environment that supports and encourages healthy behavior. The Healthy Cities approach in Europe is one model."

"We need to focus on prevention in minority and all populations. Prevention is possible at every stage. Primary prevention involves the things we think of for younger people – good diet, exercise, not smoking. Secondary prevention comes in when you already have a medical condition and want to keep it from progressing. If you have diabetes, how well do you monitor your blood sugar? How well do you follow your diet? Those things are in the hands of the healthcare consumer. The next stage is tertiary prevention, when more is wrong – for example, you've had a stroke and are in a wheelchair. Now the focus is on preventing further decline."

"We need to provide education about how to age in place and the services that are available."

"We need to educate consumers to help them make informed decisions. We need to be careful not to ignore elders with moderate rather than severe needs. For those who wind up with a chronic illness or disability, you want to give them the knowledge, skills and access to health care to keep them from getting worse. Even with a disability, you want them to maintain their maximum potential for the longest period."

"We need to get consumers information about how to manage outcomes and select providers. For example, the Pennsylvania Health Care Cost Containment Council and the Centers for Medicare and Medicaid (CMS) websites give data that allow consumers to compare facilities."

"We should find the best medium to communicate with consumers. You need to be sure the information is evidence-based, user-friendly and continually updated to reflect changes in medicine. Academic medical centers have expertise and might be good partners. Health centers are a good focus for consumer education."

"We need to incorporate exercise, relaxation therapy, music, aromatherapy, touch, yoga into the whole gamut of health promotion and preventative services."

Promising Models

"PACE is a model to keep people out of nursing homes and hospitals and reduce medical expenditures. It also responds to consumer preferences to stay at home and have responsive coordinated care. Families become well-acquainted with the team and always have somebody to answer their questions. It is a wonderful model from the providers' standpoint because of the flexibility in designing care plans. You can serve a very diverse population in a creative and individual way. Currently, it is very small scale. The classic model works pretty much only in urban areas; and it is costly to set up."

"There is a basic wish for a seamless continuum of care. One attempt at this is the PACE program. It's great for consumers who can find and use a full line of services. Given time and acceptance, that's the best health care model today for those who it's right for. But PACE will only serve a small segment of the market. The maximum is 18 to 20% market penetration."

"It is good to co-locate PACE with public housing facilities to create a sense of assisted living, a sense of service-enriched housing."

"Evercare uses nurse practitioners to help coordinate medical care for nursing home residents. The model also can be applied in retirement communities, assisted living, and the community. There is a community-based program in Massachusetts that is starting up an Evercare community-based program. It is similar to PACE but huge in scope, with thousands of enrollees. They do a risk assessment first and then have systems to target services to those who need them."

Technology to Assist Care

"With many of the high-tech in-home medical monitoring systems, there is just so much potential for error. I think they are all add-ons, not the core service. I don't think this technology is ready yet to replace the practitioner."

"Technology is a plus but it can be a barrier if it's not consumer friendly. A lot of times we don't think about the human implications. Technology should make things easier, not harder."

"Technology will pick up the slack where human resources may be limited in the delivery of in-home services. If technology is affordable, it can help those who are homebound, especially by preventing isolation. They can have contact with the outside world, besides through a home health aide."

"Right now, the best technology is a telephone-based system for risk stratification and follow-up so that people don't fall through the cracks. We need to determine who needs telephone contact once a week or once a month, and who needs a home visit with a nurse or an office visit with a nurse practitioner or physician."

"Technology can monitor how well someone is doing in the community. You can install motion sensors in a home and figure out what the resident's typical daily activities are. Once that benchmark has been set, any deviation would trigger a message to a caregiver – for example, to say that 'Your mother is usually taking a shower at this time and she hasn't been there yet.'"

"We don't necessarily need new technology but we do need to make sure that people with disabilities optimize the use of existing technologies. Many older Americans in nursing homes do not have wheelchairs properly fitted to their needs. People have wheelchairs that they can't power themselves, and they have to be pushed around by staff or they're left sitting all day in the same spot. Just matching people up with power or manual wheelchairs is a big step. Assistive technology, like augmentative communication devices, is amazing, but it's not matched up to the people who need it most because of funding and administrative issues."

Immigrant Health Issues

"In our hospital, we serve people from all continents, all demographic and all cultural groups. Building cultural acceptance and overcoming barriers is a big challenge. As immigrant populations age, one of the most important issues will be how we respect, interpret and integrate their medical and cultural traditions into the care we provide."

"We have translated materials and translators by phone and in person for our patient population. Our newest commitment is to recruit physicians who are more representative of the cultures that we serve."

"We have relationships with ethnic communities for which we have brought in federal funds for caregiver training and social work. We do best when we partner with community organizations to achieve our goals. We involve them from the beginning. We always benefit by working in partnership rather than doing it alone."

HIV

"We need to be mindful of people with HIV who are getting older and will be part of our community. I think the city needs to be poised to support this group of people."

Facilities for Neurologically- and Behaviorally-Challenged Seniors

"We have more people with Alzheimer's disease and behavioral symptoms, but there aren't many facilities to take care of them properly. Nursing homes tend not to want these people and this is becoming an increasing problem. We need facilities to specialize in care of older people with Alzheimer's, and training for regular nursing homes as well."

Advance Care Planning and End-of-Life Care

"Most people don't understand the natural life to death trajectory. Health care providers should educate people about their illnesses. For instance, what is the likely medical future for someone after a first heart attack? How does that differ from person to person? What is the total picture taking into account all of a person's medical conditions? What can be done to improve the outlook? People need to think about what kinds of care they do or don't want down the road. The whole society and the aging community need to do a better job of that."

"In the PACE model, we have quite an intimate relationship with the families and participants. We can do the kind of education that really helps people understand, develop and articulate a plan for their health care and for their dying that may or may not involve the hospital. This is one of those wonderful alignments where what's clinically sound and financially sound are the same."

Inadequate Supply of Well-Trained Providers

"We need to have first-rate primary care available. In a number of neighborhoods, access to primary care has gotten worse over the last ten years. Primary care is not a particularly attractive discipline. Primary care practices are like small businesses and are difficult to run."

"Another issue is lack of awareness of the value and enjoyment of working in geriatrics. Nearly 80% of the people who first get a job in geriatrics get there by default and they find out they love it. Students in medical school and training for community and mental health professions need to experience interdisciplinary training in geriatric settings and to understand geriatric-related community mental health issues. But getting students interested is really hard. Medical students enter as idealists in their first year. But by the third or fourth year they are thinking about how to pay back their loans and achieve the lifestyle they want. Medical education for geriatric care is still a long way from where it needs to be."

"The medical malpractice situation and loss of specialists is a real concern. In geriatrics, the important specialties include orthopedics, general surgeons, surgical oncologists and cardiologists. It is already difficult to recruit these doctors. It will take a few more years to hit consumers that there is a real problem, and then a few more years to get reform."

"All physicians, no matter what their specialty, need to know how to deal with elderly patients who come into their office."

"Nurse practitioners and physician assistants are the answer to a lot of the future medical care delivery needs in metropolitan areas. We should provide them, as well as physicians, with more geriatrics training. It's starting but needs to expand."

"My experience is that a nurse practitioner enables you to enhance and expand your practice. Nurse practitioners can return phone calls, have advance care planning discussions with patients and families, and see patients as well."

"We are struggling to find nurse practitioners and physician assistants, but I guess they want to take care of different populations. Also, there is an educational problem in getting physicians to want to work with nurse practitioners. They think nurse practitioners will take away business."

Direct Care Workforce Shortage

"It's hard to attract home health care workers when McDonald's pays more. We really just need to pay a living wage to get people to take care of another human being. If all you're paying is minimum wage, trying to keep employees by offering more recognition and training is nonsense and a waste of energy. Being a home health care worker requires heavy physical labor and deep psychic human involvement. Unless society is willing to pay more to take care of our parents, we will get transient, poor service. You get what you pay for."

"Not dealing with the funding and personnel issues (training, support and compensation) will lead to problems with abuse and neglect of older people."

"We are going to have a desperate need for direct caregivers in the future. Organizations need to offer direct care-givers good pay, good training, good support, and good benefits. They need this to attract new people into the care provider work force. Under-paid, under-appreciated caregivers have done this work forever. That's a huge issue."

"There is an opportunity to get more in-home service workers trained before the demand outweighs the supply."

"There are issues of retention and turnover with respect to community-based attendant care workers. The more educated consumer tends to hang onto their attendant longer than an uneducated consumer. The wages could be higher, and a lack of benefits is a problem for many of the attendant care workers. Efforts are underway in Pennsylvania

and in other parts of the country by unions to organize attendant care workers to achieve higher wages, benefits, vacation pay and so on."

"We need to figure out how to value hands-on caregivers such as nurse aides. They are not adequately trained or compensated for this very difficult work. Current levels of pay do not reflect the value of their work."

"The pay and benefits for caregivers in long-term care settings are so inadequate that we are giving the message that this work, and those who do it, are not important. We see 100 to 120% turnover in nursing assistant jobs in nursing homes."

"As the entire workforce shrinks, there are status issues associated with the nursing profession. Nurses in their 30s, 40s and 50s entered the profession because there was professional prestige associated with it. That's not the case anymore."

"There is a bias and hierarchy within health care between the ICU nurse, the specialty nurse, and the nursing home nurse. There are nurses who say, 'Why should I clean somebody's behind when I could be in an operating room.' But it's very nice when other people say, 'That could be your mother you are taking care of.' Nursing homes have been so bashed that we forget the people who actually work in them."

"After hospitals cut back, nursing school enrollment shrank, and hasn't picked up since. Nursing really requires a four year degree. Two year nursing programs are becoming extinct. Hospital nursing programs have disappeared."

"If people are going to be moved out of nursing homes, we need to have the infrastructure, people and services ready to deal with their needs. Somebody needs to be concerned with the individuals who will go into these homes and provide service. Somebody needs to look at the kind of education they get, their pay rate and their benefits. If these extremely important issues are not addressed, we're going to leave a lot of people high and dry."

"People who live in Philadelphia don't see the mental health needs of the elderly as a priority. Everything that needs to be improved is tapped out in terms of funding. In the future, we're going to have less money to work with this population. So we're going to continue to get people to work in this field who don't get paid a whole lot while the job itself will be even more demanding."

"As a community we haven't taken a hard look at the issues surrounding labor shortages at social service agencies that serve the aging. I guess the feeling is that we are getting by. Or, it's possible that this problem has just remained hidden or suppressed."

"We already find that the social work field is flooded with borderline people in terms of caring and ability. There are an awful lot of people in this field because they couldn't cut it anywhere else. They really lack a work ethic and solid skills in writing and communication. If the workload increases and salaries remain stagnant or decline, I

think we are going to see more people like that in the field because the better qualified people are going to work somewhere else."

Social Service Bureaucracy

"Elderly people give up before they get benefits at places like Social Security or the County Assistance Office. The bureaucracy and the people who work for these agencies hinder elderly people from getting the services they are entitled to. I have found some people who work there to be rude to the elderly, almost discriminatory. You have to sit there all day to get help. I don't think these agencies are making any effort to get nicer or smarter people, or to make it a more user-friendly system. I recently had to go to Social Security to get a card. They weren't as rude to me as they were to some of the older people. They were more patient to me, and it was noticeable."

"As baby boomers age, they will be more educated, more aware and involved with their health. Staff will need to be more patient and knowledgeable to work with a more savvy population. They need to understand consumers' rights and entitlements and not be offended or challenged when a client wants to be involved or compare programs."

Economic Change Alters Aging Services

"Right now, the stressors for institutional and community-based organizations include the lack of availability of caregivers and what price we can afford to pay for salaries. But as the business matures beyond small, mom-and-pop businesses, we may be more able to attract and retain workers because larger for-profit corporations and not-for profit organizations will be able to offer better retirement programs, health care packages, salary and benefit packages, and corporate mobility and advancement potential. Community-based care is growing as a small but significant area of business opportunity"

"Geriatrics has the potential to become a field of choice as the U.S. economy becomes more global. Manufacturing jobs are gone forever, and won't come back to the U.S. Even good high tech jobs such as computer programming and technical support are going overseas. There will still be a tremendous need for nurses with four year degrees. Jobs in the health care industry and social services will be among the only areas of future job growth. More people will turn to social work and nursing in the future because they represent a last frontier of increasing jobs."

Leadership Turn-Over and Recruitment

"Many of the people who are currently leaders in the aging network are going to be reaching retirement age. Hopefully there will be enough young, eager people who want to fill the shoes of the people who leave. But there potentially could be a loss of that history and experience. It's important that schools graduate people who want to work in the aging network."

"We face workforce shortages due to the graying of our work force. Nursing is a physically intensive job, so people tend to exit the workforce at younger ages than other professions. This was once one of the few professions women could enter, but now many more professions are open to women. There are also cultural changes: if you have a daughter, are you going to recommend they go into nursing or that they become a biochemist for a pharmaceutical company? There are status issues – especially as the whole labor force will continue to shrink."

"Nationally we are facing a shortage of nurses, social workers, home health workers, physicians, geriatricians and gerontologists. We need to make this field more attractive."

"Burnout and stress for staff is a major personnel issue. As funding drops, we can't increase staff or their salaries. Meanwhile we face growing demand for their services. People are already working double and triple shifts. Having a workforce that is supported without burning itself out is an important consideration. People need to be stroked. We've been fighting a battle here for many, many years."

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IV. E   Mental Health

> "My husband requires a lot of care, especially with the last [third] stroke... He has problems with memory … sometimes paranoia. ... There are some things, you know, that scared me, because it could have been to the fact that he didn't think enough to come home. ... So there's a lot of caring. He's embarrassed about memory or comprehension. … But it's all right. I haven't panicked. … We just limit what we do." - Focus group participant.

Nationally, experts predict a sharp rise in the number of older people with psychiatric illnesses over the next 25 years. According to one projection, the number of people age 65 or older with major psychiatric disorders will double between 2000 and 2030 – climbing from more than 7 million in 2000 to approximately:

- 8 million in 2010;

- 11 million in 2020;

- 15 million in 2030. (Bartels, 2003)

The "Consensus Statement on the Upcoming Crisis in Geriatric Mental Health" estimates that 19.6% of older persons have a psychiatric disorder today, but the proportion may grow to 21.6% by 2030. (Jeste, 1999) The report cites three factors likely to contribute to the increase:

- The overall growth of the aging population, yielding more seniors with the potential to develop psychiatric problems as they get older.

- Reduced mortality for patients who have suffered early in life from psychiatric problems such as schizophrenia, depression and substance abuse. With gains in standards of living, and effective medical and psychiatric care, more adults with mental illness will reach age 65 and beyond.

- Aging members of the postwar generation are expected to have a higher risk of depression, anxiety disorders and substance abuse than the current cohort of seniors. In part, this may reflect a generational difference in attitudes toward mental illness, and a tendency to report mental health difficulties more readily.

Research indicates that the prevalence of emotional disorders – depression, suicide, anxiety, alcohol and drug abuse – among members of the postwar generation is approximately 3 to 4 times higher than today's elderly population nationwide (see "*Mental health care for older adults in the year 2020: A dangerous and avoided topic,*" Gerontologist, 1994). The authors anticipate that substance abuse will occur among this cohort as they age and experience chronic disability, shrinking social networks and a decline in their standard of living. Geographic mobility among members of the postwar generation (due to career choices and corporate relocations) may also have weakened their social networks and community supports.

Alcohol and Substance Abuse

Currently, alcohol and substance abuse account for approximately 10% of all cases treated by geriatric mental health facilities nationally. (Koenig et al, 1994) One forecast anticipates an increase in substance dependent and abusing adults over 50 years of age from 2.5 million in 1999 to 5 million by 2020 in the U.S. (King et al, 1994)

Older problem drinkers typically begin abusing alcohol and medications following a major life change. For older individuals, there are many such life changes: onset of chronic physical disability, shrinking social networks, declining income, retirement or death of a spouse.

While the elderly population is disproportionately female, drug abuse occurs disproportionately among men. Nationally, 3.5% of the total over 50 population are reported to have substance abuse problems. However, men are overrepresented among substance abusers: 6.2% of men over 50, compared with 1.3% of women over 50. By the year 2020, problem substance abuse is expected to be experienced by 4.5% of the over 50 population, including 7.7% of men and 1.6% of women in this age group.

The percentage of individuals over 50 with substance abuse problems in 1999 was similar across ethnic groups: 3.3% of whites, 4.9% of blacks and 4.3% of Hispanics. As shown in the table below, by 2020, the percentages are expected to be 4.4% of whites, 4.9% of blacks, and 4.5% of Hispanics.

Figure 40: Problem Substance Abuse among Persons Ages 50+, Nationally

Problem Substance Abuse Among Persons Age 50+ Nationally: 1999 Estimate & 2020 Projection (in thousands)				
	1999 Estimates		**2020 Projections**	
	# with problem substance use	% with problem substance use (standard error)	# with problem substance use	% with problem substance use (standard error)
Total	2,548	3.5 (0.4)	5,037	4.5 (0.7)
Gender				
Males	2,028	6.2 (0.7)	4,060	7.7 (1.3)
Females	519	1.3 (0.3)	977	1.6 (0.5)
Ethnicity				
Hispanic	202	4.3 (1.7)	552	4.5 (1.7)
Black - not Hispanic	321	4.9 (1.5)	593	4.9 (1.8)
White – not Hispanic	2,025	3.3 (0.4)	3,892	4.4 (0.8)
Age groups				
50-59	1,501	5.0 (0.7)	3,131	7.6 (1.5)
60-69	607	3.1 (0.6)	1,296	3.4 (0.8)
70-79	336	2.1 (0.6)	436	1.9 (0.4)
80-89	105	1.8 (0.8)	147	1.7 (0.6)
90+	0	0.0 (0.0)	26	1.2 (0.6)

Source: Gfroerer J.C. Penne M.A. Pemberton M.R. Folsom R.E. 2002. *Chapter 5: The Aging Baby Boom Cohort and Future Prevalence of Substance Abuse*, in *Substance Use by Older Adults: Estimates*

Note: Numbers were rounded. This accounts for the occasional discrepancies from the total.

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Mental Health in Philadelphia

In the 2002 PHMC household survey, most men (82%) and most women (74%) age 60 or older reported no adverse mental health problems. Approximately one in ten (9%) older adults in Philadelphia reported being diagnosed with a mental health condition. Nearly three times as many females reported a mental health diagnosis as males (11% vs. 4% respectively). Of those who reported a mental health condition, the proportion of females who reported that they obtained treatment was smaller than males, suggesting that there are many females who are not being treated for their mental health condition. (Glicksman and Norstrand, 2004a)

These figures obtained from the PHMC may very well be an undercount for various reasons relating to how the survey was conducted:

- The PHMC household survey asked respondents whether they had ever been diagnosed with any mental health condition, including clinical depression, anxiety and/or bipolar disorder. Many may not describe their mental health conditions using these terms. Instead they may acknowledge loneliness, tearfulness, hopelessness, or other descriptions.

- The survey does not explicitly ask about some mental health conditions, such as symptoms of trauma.

- The PHMC's data comes from a phone survey which makes it hard for the interviewer to ascertain mental health condition. Furthermore, mental health conditions commonly are not self-reported.

Despite these limitations, the data are important because mental impairments of all sorts are a major factor affecting the health and safety of the elderly and their caregivers.

Older persons in Philadelphia are more likely than older persons in Philadelphia's four surrounding suburban counties to experience poorer scores on four scales that are sub-measures of the depression scale that appears in the survey: negative affect (feeling sad and depressed); positive affect (lack of positive feelings); social affect (feeling that others disliked you and were unfriendly); and somatic symptoms (such as feeling restless and that everything is an effort). Those who were less educated, unmarried, impoverished or had chronic health problems were more likely to have scores that indicate more depressive symptoms. (See Glicksman and Norstrand, 2004b)

Comments from consumer focus group members help to illuminate the concerns. Participants cite isolation, loneliness, stress and fear of crime as harmful to mental health. To combat negative feelings, they recommend maintaining a regular schedule of recreational and social activities that give shape and meaning to the day, as well as maintaining a positive attitude and sense of humor about aging. They regard senior centers are a key recreational resource that should be accessed regularly.

The Philadelphia Behavioral Health System serves more than 7,000 adults age 60 and older at risk for mental health or substance abuse problems, or both, or who present with mental health symptoms requiring assessment or treatment by a mental health professional. (Behavioral Health/Aging Workgroup, 2004)

The community service system already faces significant challenges in meeting the mental health needs of older adults – both nationally and locally. Difficulties accessing mental health care for older individuals occur due to a variety of factors:

- Lack of older individuals' awareness of community-based supports;

- Lack of training among physicians to recognize and treat mental health symptoms;

- Inadequate reimbursements for mental health care from Medicaid and Medicare and

- Lack of coordinated outreach, education, prevention and crisis support. (Mental Health Association of Southeastern Pennsylvania, 2000; Jeste, 1999)

If the prevalence/incidence of mental health problems in the city's elderly population increases in the same proportions as national projections, the need for comprehensive, coordinated, easily accessible, well staffed and culturally sensitive mental health services will become even more intense.

According to the Mental Health Association of Southeastern Pennsylvania, mental health problems can diminish quality of life for individuals; and, if untreated, result in greater use of costly mental health inpatient treatment, increased physical disability, premature placement in nursing care, higher medical costs, and even death among older people. One of every four suicides in Philadelphia is committed by an older adult. (Behavioral Health/Aging Workgroup, 2004)

Alzheimer's Disease

National Projections

National projections suggest that the number of individuals afflicted with Alzheimer's disease will rise gradually over the next ten years. Between 2000 and 2010, the number of persons age 65+ with Alzheimer's is expected to rise from 4.5 million to 5.1 million, with most of that growth accounted for by individuals age 85 or older. (NIH News, 2003)

However, dramatic increases in Alzheimer's are on the longer-term time horizon. While in 2003, there were 4.5 million individuals with Alzheimer's (according to the Alzheimer's Association and NIH), this number is expected to climb by 2050. According to NIH and Alzheimer's Association projections, there will be upwards of 11.3 million individuals nationwide with Alzheimer's by 2050 (including 8 million individuals age 85 and older).

Pennsylvania Projections

The number of Pennsylvanians afflicted with Alzheimer's was 280,000 in 2000, and is expected to remain at 280,000 in 2025, according to the Alzheimer's Association, (which cited a study "State-Specific Projections Through 2025 of Alzheimer's Disease Prevalence," *Neurology*, May 11, 2004) According to the Alzheimer's Association, Pennsylvania and Rhode Island and the District of Columbia are the only areas that will not see an increase in the prevalence of Alzheimer's disease by 2025. In part this is because of the slower growth rates of the older population in these states.

Still, in 2000 the state of Pennsylvania had the fourth highest incidence of Alzheimer's nationally. According to the Alzheimer's Association, by 2025 Pennsylvania's ranking in statewide incidence of Alzheimer's is expected to shift slightly to fifth.

However, when dementias due to other factors are added to these estimates, the projected number of individuals expected to face cognitive impairments in Pennsylvania is far greater. According to this analysis, when other causes of dementias are taken into account (such as Pick's disease, Parkinson's, Creutzfeldt-Jacob disease, vascular or front-temporal dementia, and dementias with Lewy bodies), there were 466,000 such individuals in 2000. The same number is expected in 2025.

Figure 41: Alzheimer's Incidence in Pennsylvania 2000 to 2025

Alzheimer's Incidence in Pennsylvania - 2000 to 2025				
	Number of persons with Alzheimer's disease by age			% change in total number affected
Year	65-74	75-84	85+	Total	
2000	17,000	150,000	110,000	277,000	
2010	12,000	130,000	140,000	282,000	0
2020	15,000	120,000	130,000	265,000	-7
2025	17,000	140,000	130,000	287,000	0

Source: Alzheimer's Association, Delaware Valley Chapter (Wendy Campbell, President)

Figure 42: Total Estimated Dementia-Afflicted Population in Pennsylvania

Total Estimated Dementia-Afflicted Population in Pennsylvania (Alzheimer's Plus Related Dementias) – 2000-2025	
Year	Total (in thousands)
2000	466.7
2010	466.7
2020	433.3
2025	466.7

Source: Alzheimer's Association, Delaware Valley Chapter (Wendy Campbell, President)

Philadelphia Statistics

Currently, there are an estimated 32,000 cases of Alzheimer's disease among those age 65 or older. (Glicksman and Norstrand, 2004a) Almost half of those age 85 or older (47%) reported being diagnosed with Alzheimer's while only 10% of those age 65 to 84 reported an Alzheimer's diagnosis. It is important to note that these percentages pertain to Alzheimer's only and do not include other forms of dementia.

Insights from Community Leaders

Community leaders agree on the need to better integrate mental health services into mainstream health and aging services, and the need to create a pool of well-trained providers. Despite this general consensus, however, concerned individuals and organizations face complex challenges associated with the need to work collaboratively to resolve issues such as:

- How the move to consumer-directed, community-based care affects people with mental illness;

- Whether future public and private funding for mental health care will be adequate to meet expected needs;

- Whether the necessary range of mental health services exist; and

- Will mental health services for the aging rise in priority?

Increasing Service Needs

"We need a mental health care network that is more accessible. Right now, there is a huge gap between the number of people with mental illness and those who actually receive help. Creating the network will require investment, but it will be beneficial in the long run."

"By the year 2015, the 75 to 84 year old cohort might be harder to serve than the baby boomers. Many will reside in the community, and will not be attuned to mental health services or seek them on their own. The frail elderly, age 85+, may have better access. Many will be receiving intensive health services, where care providers will identify their needs, and some will be in nursing homes where mental health care is mandated."

"Baby boomers grew up with mental health services and may expect them in old age. Also, they may have greater needs because of the alcohol and substance abuse in this generation. As the baby boomers were growing up, mental health services became more available, including community mental health for low-income families. This is very different than for earlier generations."

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Inadequate Funding for Mental Health Services

"One issue is that Medicare reimburses mental health services at a lower rate than physical health. Will Medicare finally start to pay mental health professionals adequately? We need parity in payment for physical health and mental health care."

"People with mental illness will get shortchanged because there are no dollars – and they don't really have a voice. They are just going to fall through the cracks. Mental health services are often viewed as unnecessary. Even when the need is recognized, the services may not be available."

"Low reimbursement for geriatric mental health keeps people from going into the field, and discourages clinics from taking on mental health because they can't break even. Also, it discourages older people from getting help because they have higher co-payments."

"The number of places that provide mental health care for senior citizens actually is decreasing. Because of more restrictive Medicare regulations, nearly all mental health centers in the city are closing their partial hospital programs. The only programs remaining are for very poor people on Medical Assistance."

"HMOs have become much more restrictive in terms of the number of mental health visits they authorize, and that basically turns on or turns off access to care."

"People who develop late life mental health problems, and who don't have a history of being in a state hospital or being committed, don't go to the beginning of the line -- they get pushed to the back."

"More affluent seniors, the 'Volvos,' can pay for care out of pocket. Impoverished seniors are in Medicaid HMOs; and mental health services are slim to none for that group. Medicare and supplemental insurance cover the broad swath of older people with modest incomes, but there are problems with mental health care coverage here, too."

"We need a single standard of mental health insurance so that all have access."

"Access is a particular problem for people who speak another language or come from a culture that usually doesn't seek help. These folks might not know where the resources are. Typically, if you ask older people how to get mental health help, they don't know. If you add language and cultural barriers that lack of awareness becomes a real concern."

"The 85 year old male is more likely to commit suicide…yet things like mobile services for behavioral health are not reimbursed. Transportation also is an issue. As we have a growing number of older people who can't get around, that will affect their access to mental health."

Need to Integrate Mental Health Care with General Health Care

"Will the aging system become more proactive in mental health? There is a growing awareness that mental health is an important part of people's lives. There's also a growing awareness that people with mental and physical health problems are more disabled than the person with just a physical illness. Mental illness can affect compliance and other aspects of health. So, will mental health become important for aging services – not just something you refer people to but an integral part?"

"Older people who don't pose a threat to society tend to be less of a priority in the behavioral health system. Yet, older people with depression are more vulnerable to other illnesses, are less likely to get well, and are more likely to die or commit suicide."

"Mental health care should be integrated into general health care. People are more willing to accept mental health services when they are offered with physical health care. People in nursing homes and PACE (Program of All-Inclusive Care for the Elderly) accept mental health services because they come with general medical care."

"In the next ten years, I hope that we would develop a much more integrated system of primary care doctors who understand mental illness and work in tandem with mental health specialists."

"Many older adults receive prescriptions for psychotropic drugs from primary care providers who don't know how to diagnose mental health disorders. Many under treat or over-medicate, which leads to more problems."

"We need to improve the knowledge and competency of primary care doctors. Studies show that people are more likely to get mental health services through their primary care doctors. Will primary care physicians improve their understanding of detecting and treating mental illness? That's a big question."

"I hope that people will be screened for depression and other mental illnesses when they come in for a regular physical. This could help prevent more serious problems."

"We need more facilities for medically fragile seniors who also have behavioral health needs."

Impact of Community-Based Care on Older People with Mental Illness

"One of the downsides to aging in place is that chronically mentally ill people may become much more isolated. Not that nursing homes are a great alternative, but we may have people living by themselves with the potential for falls, physical distress and anxiety. I'm sure there will be a percentage that will be much happier, but some will be more cut off from someone checking on them, lifting their day, assuring they get nutritious meals and so on. We are following people's instincts to be independent yet we may make them more vulnerable."

"Will people receiving home and community-based services have access to mental health care? Are we keeping statistics on folks who are homebound and have mental illness? Are those people being treated? Care providers don't always notice mental health symptoms, and clients don't get treated. People can hold it together during a one-hour nursing visit, but the rest of the day they experience serious anxiety. What is the impact of living independently on access to mental health care?"

"In the past, people with serious mental illness typically were hospitalized at an early age. Now, we have people with chronic mental illness in the community who are receiving extensive services paid for by state hospital funds diverted to community care. Physically, they are much older than their chronological age and they have special needs. It's expensive. I would be surprised if we keep up the level of service, especially if people become more physically needy."

"We have HUD-sponsored senior housing in the city, and we should recognize that putting support groups in each one is a good preventive measure. Groups would help prevent suicides, and alleviate other types of mental distress that can occur among people in senior high rises."

Help for Families

"Older people with mental health problems are at higher risk of neglect and abuse. Abuse is much more likely when families don't know what to do with a mother or father who has depression or another mental health condition."

"You can't just treat the older adult. You have to treat the whole family system. This is especially important for families from cultures where the adult children are the gatekeepers for services. Families need to understand in terms of their own culture, what mental health issues are and how to help a parent."

"Protective services should work with mental health so that older people with dementia who are committed involuntarily aren't bounced between the two systems."

Mental Health Workforce

"Mental health workers burn out because they are not compensated well and there are so many hassles. We don't have enough clinicians now and we won't have enough in the future."

"People enter the field when they're enthused and devoted. Then they realize they need to put their children through school and they have other financial needs. They are not greedy. It's a matter of survival and fair compensation for the work they do. You put in long hours, get involved in advocacy to get someone's roof fixed. It's stressful. People come in with vision and idealism, but sooner or later, they look elsewhere. If we want to make mental health care universal, we need to increase providers' salaries."

"I hope that retired social workers and care managers will want to help the field. These folks could lead support groups. We should tap into their skills rather than retire them."

Positive Developments

"We will become more sophisticated with medicines, and more knowledgeable about the heightened risk for depression and anxiety among people with diabetes, heart problems, Parkinson's and other diseases."

"PACE is a great antidote for depression. Adult day programming doesn't help everybody, but a large percentage of participants have depression which is substantially alleviated without medication – except for those with a biochemical problem."

"In 10 years, telemedicine will be a more standard procedure than it is now. With this technology, primary care doctors can consult geriatric psychiatrists, and geriatric psychiatrists and nurses can monitor patients in their homes. One insurance company is setting up a system now for people at risk for mental illness. Over time, this will become more acceptable to older people."

Next Steps

"Today, there is a greater awareness of mental health but there isn't a consensus on what to do about it. That's what we need. I think we need to envision the continuum of care and its components."

"The health system should have an aging and behavioral health department. We need a coordinating body to make system changes and assure that there is a continuum of behavioral health care for older people."

"Pennsylvania's Mental Health Act needs a better definition of mental health. The current definition comes from the 1960s when we didn't really take dementia or the vulnerability of older people into account. The focus was on schizophrenia and younger people."

"Nationally, we need agreement on the benefit package for mental health services for people on Medicare and enrolled in HMOs."

"We must keep alive the person-to-person aspect of mental health care. We can't assume that drugs will do it all."

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Wendy Campbell, President, Alzheimer's Association, Delaware Valley Chapter

IV. F   Informal Caregiving

IV. F. 1   Eldercare

Informal Caregiving by Elders in Philadelphia

> "It was the most marvelous thing in my senior years that I could witness taking care of someone. You feel good. She loved me to death and I loved her." - Focus group participant

> "… Every day I would come home [from work], make dinner, and feed her [the neighbor]. And she would ask me to bring her some groceries. … She had to have hospice come in because I couldn't take on the stuff that was starting to go on. She wet on herself. She would poop on herself. I went in, tried to do her IV. … This was really stressful." - Focus group participant

> "I'm sending money to my sister to take care of my mom. So is my brother. ... Once or twice a year I do go to Texas to make sure she's okay. … It can be financially stressful. And I have a grandma here who is 92, ornery as hell. She's in relatively good condition, she still goes where she wants to go, but she's not the same. And I'm the only male in my family that's here; the rest are female. Everybody looks to me, what are you going to do? I'm tired, you know. I go there and I fight with her, I literally fight with her, because she's set in her ways, she doesn't want to do this. She doesn't want to do that. And … I've got a thirty year-old, a twenty-eight year-old, and a thirteen year-old. And two grandkids. …" - Focus group participant

> "My girlfriend, one of her friends, her grandmother had a stroke, and rather than put her in a facility, she brought her to her home. But she worked, so I went and I stayed with her all day." - Focus group participant

> My son lives with me, he's in his 60s. He's been on disability most of his life. He's diabetic and he's beginning to be a problem. So I have some uncomfortable feelings about our future together. I'm coming to a point where I can't care for the house as well as I'd like to. I can take care of myself, but I'm questioning whether I can take care of him." - Focus group participant

> "My husband just went through knee replacement surgery… This has not only drained me physically, but mentally. I mean because there are times that I just go downstairs to sit in the dark and I just cry because I'm tired. I'm tired, you know. It's hard to be ill yourself and still have to take care of somebody else…" - Focus group participant

> "They should have a little bit more of respite for caregivers, and just a little more help and advice for caregivers." - Focus group participant

"I still care for my mother even though she is now with my older sister, I've had her for 17, 18 years. And we have PCA, and it helps her a lot…. PCA sends a girl in every day." - Focus group participant

Informal caregivers – family members, neighbors and friends – currently provide the majority of long-term care services to older people in the U.S. In 2003, the U.S. Department of Health and Human Services (DHHS) estimated that more than 22.4 million households were serving in family caregiving roles for persons over the age of 50. The number is likely to increase rapidly as the population ages and longevity is extended. (DHHS, 2003)

In Philadelphia, the precise number of future caregivers is unknown. However, an increase is possible by 2015 as the number of elders age 85 or older (who are most vulnerable to disability and likely to need long-term assistance) rises 10%.

Complex, inter-related factors will determine the actual number of future informal caregivers in Philadelphia who are themselves over the age of 60 by the year 2015. These factors include: the size of various subgroups of the population, marriage and divorce rates, birth rates, mortality rates, labor force participation rates (particularly for women), and cultural values and expectations. (Stone, 2000)

Limited data are available on the number of elderly Philadelphians currently involved in caregiving. The PHMC Household Health Survey in 2000 indicated that 51,000 older adults (ages 60+) in Philadelphia helped care for an ailing spouse or partner, relative, friend or dependent. The average age of these caregivers was 71. Many devoted a substantial amount of time to caregiving. Philadelphia's elderly caregivers reported that they provided a median of 20 hours of assistance per week in 2000. A significant portion of these caregivers (25%) provided 40 hours of weekly care. Local caregivers reported that they have assisted relatives and friends for a median of 5 years. Of these caregivers, 25% have provided assistance for 10 years. (Glicksman and Norstrand, 2004)

Only 20% of caregivers responded to questions about the care recipient's physical and mental health. Among those responses regarding care recipient health, respondents said that two-thirds of care recipients have a physical illness or disability, close to half (41%) have impaired memory or mental ability, and 12% have an emotional or behavioral health problem.

A large number of consumer focus group participants in their 50s and 60s, and some in their 70s and 80s, were caring for family members or neighbors. These caregivers reported helping with household chores and errands, companionship, transportation, personal care, advocacy and finances. African American caregivers were more likely than Caucasians in the groups to be in poorer health at a younger age and to be caring for someone who became disabled at a younger age.

Like caregivers in local and national studies, they report a variety of stresses and strains, including juggling work and eldercare, worry about their own health problems along with

those of another person, the physical and emotional toll of caregiving and finances. Among the services that would help are: better information about the health care and social service system, help navigating them, and respite care.

Nearly half (48%) of all local elderly caregivers suffer from a chronic health condition, though most report their health to be good (43%) or fair (33%). (Glicksman and Norstrand, 2004) Caregivers report some stress (a median of 5 on a scale from 1 to 10), and nearly three-fourths report three depressive symptoms (on a scale of 1 to 10). Just under 10% (9.7%) have a mental health diagnosis. (Glicksman and Norstrand, 2004)

National Profile of Caregivers

Findings from recent national studies confirm and broaden this picture – that significantly more elderly Philadelphians provide more hours of care per week over a longer period of time when compared to national trends for all adults.

A 2004 survey by the National Alliance for Caregivers and AARP focused on caregivers of all ages who were assisting adults age 18 or above. The report found that 44 million Americans, or one in five adults of all ages, are involved in caregiving at some level. Nearly half of caregivers (48%) nationally provide eight hours or less of care per week. One in five (17%) nationally provides more than 40 hours of care per week (compared to 25% of Philadelphians ages 60+ who provide 40 hours of care a week). The average length of caregiving nationally is 4.3 years nationally (compared to a median length of caregiving in Philadelphia among individuals ages 60+ of 5 years).

This survey, _Caregiving in the U.S.,_ produced the following profile of American caregivers and care recipients:

Care recipients

- Most care recipients are women (65%), and many are widowed (42%).

- Most (79%) care recipients are age 50 or older. The average age of older care recipients is 75. Caregivers cite aging, diabetes, cancer and heart disease as the major problems facing their loved ones. Mental impairments such as Alzheimer's disease, dementia or confusion affect 25% of the care recipients. Typically, the care recipient is a parent or grandparent.

- One in five care recipients is between the ages of 18 to 49. Among younger care recipients (average age 33), the most common problems are mental illness or depression. Mental retardation accounts for 5% of the cases. Younger care recipients are likely to be cared for by parent(s), a sibling or a non-relative.

Caregivers

- Almost 7 in 10 (69%) caregivers help one person, and 22% care for two people.

- The typical caregiver is a 46 year old woman, who is married or living with a partner (62%), has at least some college experience and provides more than 20 hours of care each week to her mother.

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- Most caregivers have worked and managed caregiving responsibilities at the same time (59%). Of these, 62% say they had to make some work-related adjustments to help the person they care for.

- More than one in three (37%) caregivers say they have been shouldering the eldercare responsibility themselves in the past year. Approximately half (48%) of caregivers have asked for or used at least one outside service for the care recipient.

- Caregivers providing more intensive assistance are more likely to experience physical strain, emotional stress and financial hardship.

- 67% of caregivers say they need help or information about services. The most frequently reported unmet needs were 'finding time for myself' (35%), managing emotional and physical stress (29%) and balancing work and family responsibilities (29%).

- African American caregivers are more likely to have children at home, to be single and working than white caregivers. They are also more likely to view caregiving as a financial hardship.

- Hispanic caregivers are more likely to live with the person they care for and provide more intensive assistance than whites.

This study characterizes the extent to which many caregivers nationally face significant challenges. Some are strapped financially. Others must contend with their own age-related health problems along with those of the person they are caring for. Others are in the so-called "sandwich generation" – in the workforce, caring for children at home, and maintaining eldercare responsibilities.

Over the next 10 years, caregivers nationally and locally are likely to continue to face similar challenges. However, as the health care and long-term care systems shift care away from inpatient and institutional settings and into the community, caregivers may find themselves with a greater range and depth of responsibility in caring for aging or disabled loved ones at home. In addition, continued changes in family structure – particularly divorce, remarriage and relocation – may intensify the burden associated with caregiving.

Supportive services can help alleviate the strains of caregiving. In the years to come, there will be a continuing need for creative information, assessment, referral and connection to services, assistive devices and home modifications, education and training, support groups and counseling, respite care and financial support services to aid the region's caregivers. (Thompson, 2004)

Insights from Community Leaders

Opinion leaders view caregiving as a hidden issue, due to its informal nature, that will take on greater prominence and complexity as the size of Philadelphia's older population grows.

More Pressure for Caregivers

"We will see a dramatic increase in the number of elders who will outlive their family and social support systems. They will have no natural system of support in place. I also expect a significant increase in the need for legal guardians to be appointed for these people – or the need for radical changes in the law to obviate the need for guardianship."

"With an aging, frail population, there is definitely chronic disease. People may not die from strokes or heart attacks, but they will have to manage these conditions. For frailer people whose income is not so great, they will need help from caregivers – both formal and informal. This trend will continue, and this will impact the health care system."

"There's the sandwich generation issue. Many caregivers will have the added stress of caring for their parents and their children at the same time."

"We must come to grips with the idea that most elderly people are being helped by informal caregivers (friends and family) who need support. We often wait too long to offer support to these caregivers."

Need for Caregiver Training

"We expect that the caregiving population will increase, and that they will need to be educated on what to expect and what they need."

"Whenever possible, it's best to maintain an elder at home. But that can only happen if caregivers have appropriate training plus logistical and financial support."

Respite

"We should be talking about providing respite care for families without getting stuck in the box of what age the person is. People who have kids with disabilities need respite. And people who are caring for older adults need respite. Yet they don't talk to each other."

Caregiving for Isolated Seniors

"Some caregiving challenges are unique to elderly immigrants. Their caregivers are burdened by the same demands that other caregivers juggle, but there is an added layer. Elderly parents may not be as adapted to U.S. culture, may find it challenging to speak and understand English when it's their second language, and may not know about the services and organizations that could meet their needs."

"We need to develop social models for providing care for people who have smaller and/or working families and can no longer function independently."

Legal Issues for Caregivers

"Legal services for the elderly are massively under-funded. In real dollars, there is less money for this than there was in the 1980s. There is huge demand, and yet there are whole areas where legal services for the elderly just aren't available. Some Pennsylvania counties have no legal services at all."

"Elder law has become synonymous with Medicaid estate planning."

"I expect a significant increase in the need for legal guardians to be appointed for people with dementia or other forms of illness – unless there are radical changes in the law to obviate the need for guardianship. Issues include: who will and can be a guardian, and is there a need for public guardians? Pennsylvania has a long-standing body of law that has declined to recognize dementia as a mental illness. We have an increase in the absolute number of people with mental illness in Pennsylvania because we are living longer."

"The need for legal services for the elderly will increase as we try to keep people in their homes. We need to resolve guardianship issues and put regulations in place that can work within the developing trend for in-home care."

"In Philadelphia, most older people's only possession of note is their home – which in most cases is not worth a great deal of money. There is now a movement to allow an older person to give their house to their children rather than figure the value in their eligibility for benefits such as long-term care."

"In terms of decision-making, we need to better define the interface between surrogacy, advanced planning and acceptable risks that we associate with aging in place. Technology may play a role in adjusting our perception of and the acceptability of risk while aging in place. Again, there is the question of the role of the guardian: who is legally able to determine acceptable risk?"

"There is a real need for representation of people in guardianship. There are no legal services funded to do it."

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IV. F. 2   Grandparenting

> "I got two great-great. … I think they are great-nephews, 13 and 14. They just dropped in my hands the last year. … These boys, their mother's deceased. So it's like I'm starting all over. My baby boy is 27. … I was telling him, 'I'm tired of maintaining the house,' and here they come. So family life is a reality. I just don't have the patience for it. … It all comes down on grandma, here comes more children. … I'd really like to go and be able to settle down, but … all my nephews, great-nephews, nieces, everybody comes to Aunt Maxie. I'm here to help everybody. I want somebody to help me. I'm tired of taking care of everybody. I want somebody to take care of me." - Focus group participant

> "They is in such bad shape, the grandparents. Because, believe it or not, they have so much trouble trying to get different types of funds for them, and they need everything: clothes, books, play toys, support, money, food. I mean, they just need everything because grandparents, they don't really have no income. … They try to do it with the income that they have. … Some of them are still trying to work. And some of them, most of them, have two or three grandchildren they are trying to raise and take care of. … And they do get funds, and they do get some money, but they give them such a hard time to try to get that support that they need." - Focus group participant

Nationally, during the 10 years ending 2000, the number of grandparents caring for grandchildren spiked 30%. (AARP, October 2003) Across the United States, 4.5 million children currently live in households headed by grandparents. While no one can predict conclusively whether this trend will continue, the underlying social and economic factors contributing to grandparents' emerging role as caregivers remain in place.

Similar trends are occurring statewide and in Philadelphia. In Pennsylvania, approximately 80,000 grandparents report they are responsible for their grandchildren who live with them. Twenty-eight percent of the grandparents are African American, 6% are Hispanic/Latino, 62% are white. Thirty-five percent of these grandparents live in households without the children's parents present. (AARP, October 2003)

In Philadelphia in 2000, approximately 7,775 grandparents age 60 or older reported that they were responsible for their grandchildren and that they lived in households without an adult present between the ages of 18 to 59. However, another older person (ages 60+) was present in nearly half of these households (49%). In 45% of these households, one older adult shouldered this responsibility alone. While most grandparents (54%) cared for one grandchild, 27% had two grandchildren at home, and 18% had 3 or 4 grandchildren at home.

In Philadelphia in 2000, most seniors who were responsible for their grandchildren were age 60 to 74 years old (65%), but more than one-third (35%) were 75 or older. Close to two-thirds (64%) were female. Approximately half (52%) had a household income of less than $14,500.

More than half (68%) of caregiving grandparents in Philadelphia were African American and one-quarter (25%) were Caucasian. There were insufficient numbers in the data sample to determine proportion of grandparents for other ethnic groups.

Many factors account for the rise in grandparent-maintained households. Among them were: alcohol and drug abuse, mental health problems, teen pregnancy, unemployment, poverty, loss of a parent through illness such as HIV/AIDS, divorce, death or incarceration, family violence and child abuse. (Frantz and Steinig, 2002) Unless these profound societal problems change for the better during the next decade, there is no reason to foresee a turnaround in the trend toward grandparent care.

Older adults are typically thrust into the grandparenting role unexpectedly. As they find themselves raising a second family in their later years, a substantial number face challenges in the realms of finance, education, legal concerns, housing, and physical and mental health. This community of elders is likely to continue to need a wide range of supports to carry out their often extensive and unanticipated caregiving responsibilities. (Frantz and Steinig, 2002) Some consumer focus group participants recounted the complexity of juggling care for multiple generations – parents, children, grandchildren and great-grandchildren.

Insights from Community Leaders

The growing number of grandparents caring for their grandchildren – nationally and locally – raises new issues for aging service providers. Community leaders say that aging service providers may need to support the needs of grandparents caring for grandchildren even before they reach the age of 60. More research and definition may also be needed to identify how these grandparents can be supported and trained to cope with their own needs while they also care for their grandchildren.

"Kinship care is more of an issue when so many grandmothers are caring for their grandchildren. We have grandparents raising grandkids who can't get PCA services because they're not yet 60 years old. We need to get out of our old age-defined boxes and have the aging network be more fully integrated with what happens in Philadelphia."

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IV. G Civic Engagement and Volunteerism

"… Since I retired, my life has never a dull moment because I work with the church group. I work with the community group. I have a defibrillator in my heart. I have a support group; I'm the recreational person for that. I take them on a trip or do something with them every year. … My life is so full that the days I choose to be in the house [it's] because I'm resting. … I wish that all seniors would have the full life that I have." – Focus group participant

"To be able to offer a service, to be involved in the community with other people, I think is critical. Then you are not lonely, per se, you're not sad and blue."
 – Focus group participant

"When you're older, what do you do? How much television can you watch? How many books can you read? How much bingo can you play? How many casinos can you visit? There's nothing to do. People get sick, I think, sometimes because there isn't something to do." – Focus group participant

"Belong to senior centers, be around people. I come [home] at night to an empty house but I think: tomorrow, I'm coming back. Just being around people, talking to them and listening to them, it helps me get through." – Focus group participant

"You have to keep active, you have to be with people." – Focus group participant

"My life is full. I have a social life, dates, a little bit of sports. It's just a beautiful life." – Focus group participant

"I think that what makes me happy is having something to do in the morning. Something gets you up and going on a regular basis. I think that's very important. Senior centers, they seem to be really good. Because I belong to one… They have quite an array of different things that you can do… I think it feels good when you've got something to do…" – Focus group participant

Future trends in volunteerism among seniors are not clear cut for many reasons. Not surprisingly, age, health, income and education factor into rates of volunteerism. Better financial status and education are associated with volunteering. But other variables can interact in unexpected ways. For example, women in the U.S. traditionally have volunteered at higher rates than men. (BLS, 2002) As women increase their participation in the labor force even at later ages, it would seem that the number of potential volunteers would diminish.

However, some research shows that if people remain active in the work force longer, they will be in touch with the kinds of social networks that lead to volunteering. (Harvard-Met Life 2004) How all these factors will add up in the future is difficult for experts to project.

Of all the age groups, adults age 35 to 54 are most likely to volunteer with or through an organization. A 2002 Bureau of Labor Statistics (BLS) survey found that approximately one in three adults in age 35 to 54 had volunteered during the previous 12 months. By comparison, nearly one in four (23%) adults age 65 or older had volunteered during the same period.

However, people who do volunteer in retirement donate more of their time – a median of 96 hours annually – than any other age group (as compared to a median of 52 hours for volunteers of all ages). Older volunteers are more likely to donate their time mainly to faith-based organizations. (BLS, 2002)

The generation now in their 70s (parents of the postwar generation) currently show an additional peak in the frequency of volunteering during their 70s, unlike the generation preceding them. However, it is unclear whether the postwar generation will mirror their parents' pattern of volunteerism. (Harvard-Met Life 2004) Members of the postwar generation have been less civically engaged over their lives than their parents' generation. (Harvard-Met Life, 2004)

A 2003 AARP study of adults who volunteer through formal organizations as well as informally (with community groups, or helping neighbors and friends), found that half (51%) of people age 58 to 69 reported volunteering for a nonprofit organization, charity, religious organization, civic or other group and 35% reported helping the community or someone in need who was not a member of their family. Among those age 70 and up, the numbers were slightly lower for formal volunteerism (40% volunteered for a formal organization) and slightly higher (40%) for volunteering their time informally.

To encourage greater participation by the city's increasingly diverse older volunteers, communities and organizations may need to test creative new ways to recruit and use volunteers, including offering a broader array of roles, schedules and options for involvement, and offering small stipends as an inducement. (Harvard-Met Life, 2004) (Hart, 2002)

Volunteerism offers tangible and intangible benefits for participants:

- Building social cohesion through inter-generational programs;

- Tapping the intellectual, organizational and strategic skills of older volunteers and

- Indirectly contributing to the vitality of older individuals. Increasingly, research shows a strong correlation between social engagement and health and longevity. (Harvard-Met Life 2004) When volunteers help others, they contribute to their own well-being, as well.

Insights from Community Leaders

While volunteering is typically viewed as a discretionary activity among the elderly, aging experts view volunteering as a vital element of healthy aging. Volunteering not

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only provides a sense of purpose and meaning, experts also believe that it is an underutilized, unrecognized and undervalued future resource for the city of Philadelphia.

Volunteering Adds Meaning

"Organizations need to think differently about how to use volunteers and how to integrate them into the work force so that they're engaged in a meaningful way. We need to think in a different way about how retired people can use their skills to benefit the community and make them feel good."

"It should be normative for people to say 'I feel it's part of who I am to make a contribution in a meaningful way to my community. I am going to start when I'm five. And I'm going to figure out how to do that even when I'm 95. It doesn't matter whether I speak English or not. It doesn't matter if I have a disability or not, there are going to be opportunities that are citywide for me to make a difference and feel good about myself.'"

"We're so hung up on providing personal care to people who are frail when what they really want to feel is that they are not useless. We should intentionally plan opportunities for them to make a contribution to the community. They need someone to talk to and activities that connect them to the rest of the world, that help them feel that their life has meaning. We should be looking at frail people differently, to see what they can contribute as well as what we can give them. For example, when older people volunteer with children it helps prepare kids to deal with the world, their parents and grandparents, and it also helps older people feel connected to the mainstream."

"I hope that ten years from now people will say 'This is a win-win. Look at these older people in the community. They're helping in the schools, helping in this and that.' And in turn, I hope that we are going to create programs that support them in their homes as they age in place. We need to create opportunities that will prepare our young people to live in this aging society. We should be proactive, see the growing aging population not as a strain, but as an opportunity for how older people can contribute to the community."

"We need to find ways for older people to interact in some productive ways, to encourage healthy interaction and mutual support."

Education and Longevity

"It's a tragedy for people to retire and rust. They become passive and helpless."

"When we spoke with seniors about what they want, a lot of people talked about education. Not just education in terms of going to classes, but an opportunity to learn new skills, new information, and to use their existing skills so that they can continue to be productive."

"Research indicates that if you have social ties and you engage in productive activities, this is related to longevity. The aging network should be proactive about facilitating

social ties and creating opportunities to be productive. The aging network has always been reactive, looking at 'here are the needs – we're overwhelmed.' Instead let's ask questions about what people want, and create services that are conducive to healthy aging, services that help older people have a meaningful life that makes them want to stay in Philadelphia."

"In the coming decades, there will be a whole lot more older people either newly retired or semi-retired who are going to want to take advantage of volunteer opportunities. Not necessarily just among aging people, but in all aspects of life. I think older people are going to be a real resource for the city of Philadelphia."

"We need to increase awareness among elders about the opportunities and benefits of remaining active, find new ways for them to use their skills, and get them involved as volunteers earlier in their retirement years."

"More colleges are offering free tuition for people over a certain age. People are going to want to go to college later in life and have meaningful employment in volunteering. If you are going to be living in a community you don't want to just sit there and watch reruns or whatever horrible new TV show is out there."

"We need to figure out how to facilitate aging with dignity and purpose – not just in Philadelphia, but in the U.S.A. and globally."

Engage in Civic Issues

"We have thousands of women in the city, older women who volunteer but never raise issues that are of primarily concern to them as a group. For instance, women's health issues haven't been as thoroughly explored or funded as men's health issues. Parenting issues are of great concern when so many grandmothers are raising their grandchildren. And, of course, there are issues of skyrocketing drug costs and the future of Social Security for women. Elderly women should be equipped to raise those issues in the organizations where they volunteer so that there is more generalized knowledge about these problems. Together they might develop some helpful policy solutions."

"We want to train older women to become more equipped civic leaders so that they can provide leadership in community organizations, and together they can figure out ways to help older women cope. Their leadership can really elevate how we behave as a society and how we utilize the power of our future aging community. Tapping their expertise would be a tremendous opportunity for Philadelphia."

"What is the school system doing to recruit older volunteers to come into the schools and to assist kids with programs at the neighborhood level? What are the schools doing to get kids involved with working with older people and being a support system and being intergenerational? All of this could take shape in modest but meaningful steps."

"We should empower older people – tap into rather than retire older people's skills. For instance, when people who used to be social workers and care managers retire, they could be tapped to lead support groups."

"We need to build a community that facilitates personal growth, learning, and civic engagement."

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IV. H   Distinct Populations

IV. H. 1   Gay, Lesbian, Bisexual and Transgender Seniors

The precise number of Gay, Lesbian, Bisexual and Transgender (GLBT) seniors in Philadelphia is unknown. However, the national estimate is that 3 to 8 percent of the current population age 65 or older is gay, lesbian or bisexual. This would translate to 1 to 3 million individuals in the U.S. This proportion is expected to remain unchanged in the years to come – though the number who publicly identify as GLBT will most likely increase, as the stigma attached to this group diminishes. Applying this 3 to 8 percent proportion to the projected total population of Philadelphians over age 65 by the year 2015 (190,640 older people) would result in a rough estimate of 5,700 to 15,000 gay, lesbian and bisexual elders in Philadelphia at that time. However, this number cannot be viewed as predictive. (Cahill et al 2000; Cantor et al, 2004) It is important to note that there are no national data available on transgender people in the U.S. so it is not possible to project the size of the senior transgender population. (Cantor et al, 2004)

2000 Census

The 2000 U.S. Census found that 594,391 self-identified as same-sex unmarried partners, representing nearly 1.2 million gay and lesbian adults. This is up significantly from 1990, the first year the census allowed unmarried, cohabiting adult partners to identify themselves as "unmarried partners." Some 145,130 same-sex couples were reported that year. Several factors may account for the increase between 1990 and 2000: public education campaigns to encourage gay and lesbian people to identify themselves in the 2000 census, rising visibility of gay and lesbian people in society at large, and data-handling changes at the Census. (Bradford et al, 2002)

Despite the increase, the 2000 data likely reflect an undercount of the gay and lesbian population. Although the census collects information on same-sex couples who live together, it does not capture data about single GLBT people, those who are in same-sex relationships but do not live together, GLBT youth living with their parents, GLBT seniors who live with their children or grandchildren and do not live with a partner, many homeless people, many undocumented GLBT immigrants and those who do not feel comfortable acknowledging their status to a government agency. Also, the number of transgender and bisexual people is not identified. (Bradford et al, 2002)

The GLBT population is as heterogeneous, ethnically, economically and in other ways, as the general older population. However, currently GLBT elders face a number of specific legal, medical, and social challenges:

- Discrimination (overt and covert);
- HIV/AIDS;
- Lack of access to financial benefits and entitlements (including Social Security survivor benefits, pensions, tax-free roll-over of IRAs and other benefits available to members of heterosexual couples);

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- Loss of a home when a partner needs Medicaid-financed nursing home care;

- Lack of inheritance rights;

- Lack of medical decision-making rights;

- Lack of visitation rights when a partner is hospitalized;

- Social isolation;

- Lack of family support. (Cahill et al, 2000; City and County of San Francisco, 2003)

Additionally, GLBT elders face more subtle and pervasive challenges in housing, social services and medical care – due to homophobia, lack of awareness, fear of disclosure by GLBT elders, and assumptions and stereotypes.

Caregiving and the GLBT Population

A recent report, *Caregiving Among Older Lesbian, Gay, Bisexual, and Transgender New Yorkers,* discusses findings from the first large-scale survey of caregiving among GLBT people. The project involved 341 GLBT New Yorkers age 50 and older recruited through local GLBT organizations. Because the survey was not random, and focuses only on New York, the results may not be generalizable to all GLBT populations. Still, the information may be useful in anticipating future trends. (Cantor et al, 2004)

Overall, the survey found that nearly half (46%) of respondents were active caregivers or had provided care during the past five years. The study reports on two types of caregivers: those caring for someone from their family of origin, typically parents, other elderly relatives and children; and those caring for a member of their family of choice, including same-sex partners and close friends. Together, caregivers in both groups had provided care for an average of eight years. (Cantor et al, 2004)

Looking at demographic characteristics, 46 percent of the respondents were between 50 and 59, 35 percent were between 60 and 69, 19 percent were 70 and older. Fifty-two percent were single, and 40 percent had partners. One in five respondents had children, and 7 percent were grandparents. (National Gay and Lesbian Task Force, 2004)

Caring For a Family of Origin Member

Twenty-two percent of study participants were caring for a member of their family of origin or had given such care within the past five years. Two-thirds were the primary caregivers; almost half provided assistance on a daily basis, and another 24% provided care several times a week. Family of origin members needed assistance because of physical illness (50 percent), frailty due to old age (42 percent), dementia (35 percent), and other problems.

Those caring for a family of origin member tended to arrange for services, provide advocacy, and assure that appropriate services were being provided. Sixty percent offered financial help sometimes or often.

Two-thirds of GLBT caregivers reported that their sexual orientation made no difference in their family's expectations regarding caregiving. However, one-third reported that family expected more of them because they were GLBT, and thought to have fewer explicit family responsibilities (an assumption that was not always true).

Caring For a Family of Choice Member

Those caring for a family of choice member were more likely to live with the care recipient, and were more involved in personal care and household caregiving. (Cantor et al, 2004) In the last five years, 24 percent of respondents had assisted a family of choice member, and 30 percent of those were active caregivers when the survey took place.

In over half the cases (54 percent), care recipients were either the partner or significant other of the GLBT caregiver. HIV/AIDS (41 percent), other physical illnesses (36 percent), disability (19 percent), mental illness (8 percent), frailty due to old age (8 percent) and dementia (7 percent) were among the reasons family of choice members needed help.

Fifty-eight percent of family of choice caregivers provided care on a daily basis, and 23 percent assisted several times per week. Most (72%) family of choice caregivers served as a liaison to other family members on behalf of the care recipient "often" or "sometimes." About two-thirds (63%) "always" or "often" dealt with medical providers (63%) or had been involved in arranging medical care (64%). Half provided financial help "often" or "sometimes."

Both Types of Family Members

Both family of origin and family of choice caregivers indicated that the most important assistance they provided was emotional support but help with advice and decision-making also had high value. (Cantor et al, 2004)

Nearly three-quarters of GLBT caregivers experienced "moderate" to a "great deal" of emotional stress related to caregiving, and more than one in four expressed a need for psychological and emotional support from the community.

Community Services

The study found "low use of community services" by GLBT caregivers. About 40 percent of GLBT caregivers had used visiting nurses and/or home health aides. Female caregivers were more likely to access community services than male caregivers.

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The GLBT community-based services in which the respondents were most interested were counseling (26 percent), retirement or assisted living communities (19 percent), visiting services (19 percent), and assistance with day-to-day tasks (14 percent).

The report cites the need for respite care, information and referral, backup services and support groups for GLBT caregivers. It suggests that GLBT organizations could offer caregiver support services directly, as well as link with other community agencies to raise awareness of the available programs.

At least one-third of caregivers said that the GLBT community should play a key role in meeting the needs of GLBT caregivers. When asked why, most respondents indicated that the community was best at caring for its own members, reflecting a belief in the persistence of discrimination, according to the study authors.

Barriers to Service

Caregiving Among Older Lesbian, Gay, Bisexual, and Transgender New Yorkers points to a number of barriers to care for GLBT caregivers and their families:

- Generally, the mental health system has been slow to address issues of sexuality and aging, and needs treatment approaches sensitive to the concerns of GLBT people. For example, some GLBT people are uncomfortable disclosing their sexual orientation or gender identity in support group or group therapy settings. GLBT organizations could provide groups where participants feel safe sharing their experiences and challenges.

- Bias against GLBT people on the part of some long-term care providers, including senior centers, nursing homes and home care assistants. There is a need for effective tolerance and diversity training.

- Currently, most health care insurance, Social Security, and the Family and Medical Leave Act do not recognize same-sex couples. This leaves GLBT families with fewer resources for caregiving and old age.

Interestingly, the report notes that 8 percent of the study sample reported that they needed caregiving themselves at the time of the survey and that 19 percent had needed caregiving assistance in the past. The authors point out that, given the relatively young age of the study respondents, "it is likely that the need for caregiving assistance will grow in the future, as the community continues to age." (Cantor et al, 2004)

Insights from Community Leaders

Themes raised by community leaders include the need for cultural competence among organizations serving gay, lesbian, bisexual, transgender (GLBT) seniors, as well as the medical issues associated with the long-term management of HIV/AIDS.

Unique Needs

"We are seeing the first group of gays and lesbians who have been out of the closet for 20 to 30 years. They are less likely than younger gays and lesbians to have long-term partners and, therefore, have no natural caretaker in place. They have been relying on an informal network of peers for help, but the network of peers is aging, too. Also, we are seeing the first wave of transgender people growing old. What are their needs and how should we serve them?"

"Many people with HIV are now living into old age. The question is: How should we care for people with co-morbid conditions, such as heart disease and HIV? Elders with HIV have special needs when it comes to accessing and paying for health care and medications."

Isolation

"In addition to the typical challenges of aging, this population has to deal with the possible social consequences associated with being 'out.' The more prejudice people perceive against GLBTs, the less likely they are to attend a center with lesbian, gay, bisexual or transgendered in its name. However, in Philadelphia, this prejudice does seem to be decreasing."

Comprehensive Services

"We need a comprehensive survey of GLBT seniors to learn about their health status, living arrangements, do they have children or a partner and other important questions."

"We need to see progress in in-home assistance, transportation, volunteer and day programs that provide structure and meaningful cultural and recreational activities for lesbian, gay and transgender seniors."

"GLBT elders have a special need for subsidized housing because they usually do not have children to help them or take them in. There is an opportunity for the GLBT community to create an elderly housing complex that will meet their needs and to create a brain trust and pool of volunteers. This is very important since retirement can now last many years."

"Mainstream and GLBT service providers should be better integrated. Also, the gay male community is separate from the lesbian community which is separate from the transgender community. Tying funds to collaborative work will help bring about integration."

Open and Sensitive Providers

"All over the country, standard GLBT programs are setting up services for seniors and dedicating more staff and space for them. But there is also a need for 'mainstream' service providers who are friendly to gay and lesbian individuals and aware of their needs."

"Service providers should be open and sensitive to people's lifestyles, and the fears they have about bringing people into their homes and being exposed. Consumer directed care, as opposed to an agency model, lets seniors hire someone sensitive to their needs."

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IV. H. 2   Philadelphia's Elderly Homeless Population

The homeless elderly are another under-recognized group. According to Arlene Bailey, Social Service Program Supervisor, Office of Emergency Shelter & Services for the City of Philadelphia, there were 325 individuals ages 60+ in city shelters in 2002. In 2003, the number increased to 363 individuals and, in the first seven months of 2004, there were 271 people age 65+ in city shelters. It is likely that the total number of homeless elderly for 2004 will be within the same range as the previous two years (though this data was not available when this report was published). The vast majority of these shelter residents were African American and male.

According to the Administration on Aging, the number of elderly persons who are homeless nationally is likely to grow substantially as the postwar generation ages. (U.S. Department of Health and Human Services 2004)

Figure 43: Number of Persons Age 60 or Older in City of Philadelphia

Number of Persons Age 60 or Older in City of Philadelphia Office of Emergency Shelter and Services System			
			January through July
Ethnic group	**2002**	**2003**	**2004**
African American	215	250	196
Caucasian	83	75	46
Hispanic	8	12	10
West Indian	0	1	0
Indo-Chinese	0	0	0
American Indian	0	0	0
Asian	1	1	1
Biracial	1	1	0
Other	6	7	5
Unknown	11	16	13
Total	**325**	**363**	**271**
Gender			
Male	243	272	197
Female	71	75	62
Unknown	11	16	12

Source: Arlene Bailey, Personal Communication

Insights from Community Leaders

The data on recent trends in homelessness indicate only subtle changes in the elderly homeless population. But community leaders serving the homeless describe disturbing and unmet needs that are expected to grow in the coming decades. They see the experiences of elderly individuals in homeless shelters as an indicator of the problems caused by chronic, growing gaps elsewhere in the elder care system.

Causes of Homelessness

"Over the last three years we've seen an increase in the number of elderly persons in our shelter. I attribute it to 'system failures' – nursing homes closing, a geriatric center that closed. We get hospital discharges and mental health discharges all the time. We have hospitals discharging people at 3 a.m. without any notice, without any care and without any medication. How can you do that? Because our shelters have 24-hour reception, those people come here."

"We tell other organizations that we can't care for these people. But we do have beds – as minimal as they are. We are struggling because we don't have the staff to deal with elderly people who are homeless. They require a higher level of care even than younger people generally."

"Our shelter intake unit says that we're seeing a much older, sicker, and more disabled population coming to the shelter than we are prepared to serve. For years it was just the young substance abuser coming in or the middle aged alcoholic. Now people are older and have more medical needs when they enter the shelter system."

"We move people of all ages out of the shelter and into the community but elderly people keep coming back to the shelter because they don't know how to survive without family, social service and income supports."

"One issue when we try to access nursing homes for elderly shelter residents are that the people are using drugs even though they're elderly. Nursing homes are not structured to care for people with mental health or drug issues. They end up stuck in shelters because nursing homes won't admit people who abuse drugs."

"The trend toward de-institutionalization among mental health facilities and nursing homes is a factor that leads to increased homelessness among the elderly. If people are to stay in the community, they need more community-based support services to help with whatever they need to do."

"The challenge is to keep the homeless shelter from being the new mental health institute. If you've got the bed, you have the problem."

Housing Shortages Lead to Homelessness

"We don't want homeless shelter to be permanent housing, but there is a lack of housing to move elderly people into. For the over 60 elderly population, the waiting list for subsidized housing units for the elderly and disabled is just ungodly long. There's just not enough housing. People face two year waits on the waiting list."

"When I began working with the homeless population 20 years ago, we used to have a lot of contacts with personal care boarding homes. We seem to no longer have those. They were a perfect setting for the elderly and medically fragile people. There was one in

Southwest Philly. She was just awesome and you knew you could get a client in there and she would take care of them. The lack of new personal care boarding homes and downsizing of the remaining personal care homes has really impacted on our over 65 population. We can't get older people into those personal care homes that we might have historically. As a result, they have drifted downward into homelessness."

"There aren't enough nursing homes available, the quality is questionable and the elderly look at nursing homes as a bad, absolute desperate last choice. A lot of people over the age of 60 can't live by themselves anymore, but they don't meet the requirements for a nursing home, and they also can't afford assisted living programs."

Future Prospects for Elderly Homeless

"Without better education and employment there's going to be a perpetual increase in homelessness and dependency on our system. Right now jobs are being created, but people on minimum wages are living in shelters because they can't afford an apartment."

"Homeless agencies keep moving toward bigger shelters because they're cost effective. But it's harder for older people to survive in them. Trying to fit someone with special needs into generic big places is hard."

"We have people who are going to move into the older population who have a lot of emotional and medical problems due to drug abuse. The people who are abusing now are going to end up in that 60+ population and need treatment. The people who are using crack cocaine and marijuana aren't going to just give it up on their 60th birthday. We have to be able to work with that reality. There needs to be meaningful activity for people wherever they're living whether it's in a nursing home, a shelter or subsidized living – they have to do something besides sitting in front of a TV."

"Drug users have a side effect of increased dementia. Mental health providers say 'sorry it's not mental illness.' But these are people that have needs like those in the medical and mental health system but no one is paying attention to them. We keep trying to squeeze them into some spot where they can get the care they need. But it's hard to get funding for drug user services. You hear a lot of talk about people needing detox and rehab and having to do it over and over. People get tired of it. It's hard to get funding for drug user services."

"The availability of Social Security in years to come will greatly impact upon seniors' ability to sustain themselves and maintain themselves in their homes and communities."

New Models for Helping Homeless Elderly

"Creating permanent housing for dually-diagnosed elderly such as supportive housing for people with mental health and drug and alcohol issues has some value."

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"People need more domiciliary care where people who are older can move into a family setting if they don't want to be in institutions."

"What we're trying to do is have a centralized repository within the city social service data on clients as they enter the homeless system. So that no matter when they present at whatever point in their life, the information is available to all of the agencies from then on so that they can provide better coordination and collaboration on supportive services. One of our roadblocks to serving older people who are homeless is that you always have to recreate their history. We are trying to establish continuum support services where we are all working together to support a client so that sharing information with each other is not a prohibitive issue. This is supposed to provide a better level of service and be more efficient than everybody doing their own thing. We have people who have mental health problems, mental retardation, substance abuse, medical issues with AIDS. Everyone is doing case management all over the place. The need to coordinate services is really huge. We are not necessarily working against each other, but we are duplicating services."

"We need new models and projects to address chronic homelessness. One example would be the Housing First strategy where people coming into a shelter will get housing first and then services will be wrapped around that."

"In the future we may need to rethink our strategy in serving older individuals who are homeless. We have clients now who present on hospital beds, gurneys, and who come with all sorts of medical equipment that the staff isn't really trained to handle. I don't see that external resources are going to increase enough to keep those folks out of shelters so we may need more training so our staff is skilled to deal with issues relating to the elderly and disabled."

"One elderly disabled person can have clinical issues that can take up a lot of time. I recall one case, a man who arrived on a gurney who had substance abuse issues, had an oxygen tank, needed attendant care, and was very defiant in getting help for himself. He disappeared during the day to do whatever. We had no idea how he got around and got back. But it took so much time and effort for that one case that it was incredible."

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IV. H. 3   Seniors with Developmental Disabilities

"I have a Down syndrome son who is 36. He has no academic skills whatsoever, but he does have a job. … I have to do everything just about. … I have a little house, and I wanted to get rid of it and go into a senior citizen center. But he couldn't live with me then. And I can't live without him. That's past. I made up my mind. I'm going to stay where I am and keep him. … I can't walk and get around like I used to; and I feel sad that I'm losing my independence because I have so much to do for my son. I have to take him here, take him there. … Osteoporosis is really hindering me now. … Everything is on me because he doesn't understand even the texture of two socks. He knows that they're both black, but he doesn't know that one is heavy and the other is light. I have everything to do just about. And that is pressing me." - Focus group participant

The number of older adults with early onset disabilities affecting intellectual and social cognition, and brain function is rising rapidly. It is estimated that approximately four out of every 1,000 adults age 60 or older has an intellectual disability (terminology used instead of the phrase "mental retardation"), cerebral palsy, a genetic disorder such as Down syndrome, epilepsy, or a disorder on the autistic spectrum. (Janicki, 2001) Currently, approximately 641,000 people ages 60+ are thought to have intellectual/developmental disabilities. By 2030, this number may double to 1.2 million seniors. (Factor, 2004)

Life expectancy for people with health-related intellectual and developmental disabilities has improved dramatically in the last 50 years due to improved standards of living, medical care, housing and supportive living services. (Overeynder and Bishop, 2000) Continued gains are expected in the years to come, so that growing numbers of people with health-related developmental disabilities such as Down syndrome or cerebral palsy will live well into old age. (Overeynder and Bishop, 2000) For individuals with moderate disabilities, some experts anticipate that life expectancy may be reaching parity with the general population. For those with more severe intellectual and health-related disabilities, life expectancy may be extended beyond expectations for prior generations. (Janicki, 2001; Factor, 2004; Overeynder and Bishop, 2000)

Seniors with developmental disabilities face many of the same health and lifestyle changes as other older adults, yet the challenges are often compounded. Some older people with developmental disabilities are at greater risk for co-morbidity. For example, seniors with Down syndrome are at heightened risk for early onset of Alzheimer's disease and other disorders. (Overeynder and Bishop, 2000) Adults with cerebral palsy may lose gross motor functioning earlier than those who are unaffected. (Janicki, 2001) In addition, older adults with developmental disabilities may face especially difficult life transitions, such as the loss of parents or other family members who have been their longstanding caregivers.

More specifically, aging adults with intellectual and developmental disabilities face many of the same challenges as other aging adults – physical aging, social isolation,

disengagement from work or activities, and the financial consequences of retirement. Yet these aging-related difficulties are intensified because elderly cognitively disabled adults may have had limited social and vocational experiences, may face the loss of their family home with the infirmity or death of their parents or caregivers, and may also need alternative housing. Additionally, they may need help accessing medical and social resources, senior services, and disability-related therapy or supports. (Janicki, 2001)

In the coming decades, seniors with developmental disabilities and their caregivers are likely to have a larger presence in the community than ever before. Until the 1970s, many segments of the developmentally disabled population were institutionalized. With the shift to community-based care, it is now estimated that close to 2 million people with developmental disabilities live at home with family caregivers, one-fourth of whom may be age 50 or older. (Janicki, 2001) Over the years, there will be a growing number of families in which very elderly parents (or elderly siblings, spouses or other family members) are caring for seniors with developmental disabilities.

Caregiving families and disabled individuals are likely to be particularly vulnerable and in need of innovative programs -- such as respite, housing, adult day care, and other forms of community services available through aging, social services or disability agencies – to meet their special health, economic and psychosocial needs.

The impact of this disabled population on their elderly caregivers can be profound. According to an article in *The Wall Street Journal* ("Uneven Care as Parents Age, Agencies Struggle to Help Disabled," 10-19-04), more than 700,000 developmentally disabled people live with caregivers who are more than 60 years old in the U.S. in 2004 – up from 673,000 in 2000. Federal funding for support for these caregivers varies county-by-county.

The article states that "An aging population is straining agencies that help disabled people stay in their homes. Thirty years ago, most of the developmentally disabled lived in institutions. Today nine out of 10 live in private homes. That transformation reflects efforts by parents who insisted their fragile child remain with them. … Now, many of these parents, growing frail themselves, can no longer do everything for their disabled adult children and are increasingly turning to government-funded agencies for help."

Among the tensions faced by these caregivers are the isolation and work associated with providing this care, reluctance among some to become involved with institutional providers of care, reluctance of some parents to consider that their disabled child will outlive them, typically strong inter-dependence between caregivers and their adult child, and a profound lack of coordination of services for the disabled population both for the immediate and long-term needs of families. (Janicki, 2001)

Insights from Community Leaders

The needs of adults with developmental disabilities and their often elderly caregivers are complex and not fully addressed by social service providers and government funding, as indicated by community leaders' systemic concerns about this population.

Aging Caregivers

"Most adults with developmental disabilities are being helped by informal caregivers, both friends and family members, who also need support. Sometimes we wait too long to support these elderly caregivers. We must come to grips with this need for support and find others in the community or relatives who can function as more formal caregivers."

"We need to understand that there is a significant population of older adults with developmental disabilities and a significant number of their informal caregivers whom we don't know about. We need to talk to them. The question is how to reach out to them and help them understand that we are trying to develop a system that is supportive of them."

"We have an opportunity to keep people in their homes and out of institutions by providing adult day programs."

"The MR (mental retardation) system in Philadelphia is tough right now. They're filled. If there's somebody with mental retardation in a shelter it's very problematic. They need extra care."

Workforce Availability

"With people continuing to leave the Philadelphia area for better opportunities, workforce availability is a real issue. Salaries for working with adult individuals with developmental disabilities are not keeping pace with inflation. We are very concerned about the lack of cost of living increases in wages. We need the resources to pay this workforce a decent living wage so that we can be competitive with other professions. Skyrocketing costs of healthcare for employees are a related concern. We have real issues around how to maintain a qualified and healthy workforce."

Need for Improved Outreach

"People need education about how to age in place, and what services are available. There is a significant population of individuals with developmental disabilities and elderly caregivers that we do not know about. We need to talk to them. How do we reach out and make them understand that we are trying to develop a system that is supportive of them?"

Integration of Services

"Lack of coordination of funding, services and information to assist seniors with developmental disabilities is a critical issue for these individuals and their often elderly caregivers. The amount of important information is voluminous and not easily digestible by consumers and people in the field. We need to communicate more effectively about ways to address their unique needs. And there is a need for better integration of services for caregivers and individuals with developmental disabilities – especially when the caregiver is elderly. This will result in significant savings in time, money and effort while providing a higher level of care."

"There is absolutely a need to integrate services. The way it is now, you might be accused of double-dipping. For instance, you might need services from the Office of Mental Retardation, the Philadelphia Office of Behavioral Health, the Department of Aging, and the Social Security Administration. While there might be overlap between services, all of which you might legitimately need, there might also be a risk of being disqualified from one funding source because you receive it from another. For instance, the Office of Mental Retardation may want to shift their clients to the Department of Aging. I don't have concrete solutions, but there needs to be a resolution at some level because of the way things are going."

"Better integration requires leaders who can be flexible among and within systems that are available across disabilities without narrowly specializing in one disability. These leaders need to develop policies based on consumer-defined needs."

"I think there will be a merging of the disabled community with the aging community. We are starting to see some 'head butting' between the systems and which system needs to be paying for what service. The disabilities community also has a different kind of approach to working with people: it's much more radical and consumer focused than the aging community. The two groups are starting to collaborate a little. In the disabilities community, you need to be inclusive, and nobody can argue that point in the aging community which will have to embrace those values as well."

"People with cognitive disabilities have aged into our cohort and benefit from some of the types of interventions offered to people with age-related cognitive impairments. They fit right in. I don't mean that everybody is the same, but I do mean that the types of interventions that are available seem to work for them and we can tailor them, as well. Because there are so many elderly people with dementia, adults with developmental disabilities are very well accepted, their behavior mirrors a sort of mild dementia. They ask the same questions over and over again which may come from anxiety rather than forgetfulness but we deal with it pretty much the same way."

Self-directed Care

"In the fields of mental retardation and disability, there is a move to allow people to self-direct their services. People will have choices and be able to control their care. It's

possible that when people control their own resources they may use them in a more frugal and directed way. However, you do have to be able to account for how the money has been spent."

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IV. H. 4 Elderly Ex-Offenders

Older prisoners and ex-offenders are two potentially under-recognized yet growing populations in Philadelphia of older individuals with unique needs and vulnerabilities.

One incomplete measure of the anticipated growth of the region's elderly ex-offender population comes from the Pennsylvania Correctional Population Projection Committee (see table below). These data include only offenders ages 60+ in state prisons, and do not include numbers for individuals incarcerated in local or county jails, or federal prisons. These statistics were provided by from Douglas Hoffman, Director, Center for Research, Evaluation and Statistical Analysis, Pennsylvania Commission on Crime and Delinquency, Harrisburg.

The anticipated number of elderly Philadelphians who are in the state prison system through the year 2015 is based on the assumption that Philadelphia offenders account for 40% of the state prison population. According to this forecast of the Pennsylvania state prison population, the number of elderly in the Pennsylvania prison population will nearly double between 2003 and 2015.

Figure 44: Elderly Prison Population in Pennsylvania and Philadelphia

Elderly Prison Population in Pennsylvania and Philadelphia Growth Forecast: 2003-2015 for Individuals 60+ (in State Correctional Facilities)		
Year	**Total in Pennsylvania**	**Total in Philadelphia**
2003	1,095	438
2004	1,120	448
2005	1,173	469
2006	1,223	489
2007	1,319	528
2008	1,407	563
2009	1,522	609
2010	1,629	652
2011	1,764	706
2012	1,880	752
2013	1,998	799
2014	2,143	857
2015	2,284	914
% change 2005-2010	**+39%**	
% change 2010-2015	**+40%**	

Source: Doug Hoffman, Personal Communication

Nationally, inmates over age 50 are the fastest growing segment of the incarcerated population. While 4% of the U.S. prison population was 50 and older in 1990, that percentage increased to 8.2% in 2002, and has been estimated to be as high as 10% of the current U.S. prison population.

The national trend toward a "graying of the prison population" is more pronounced in Pennsylvania. (Commonwealth of Pennsylvania Department of Corrections, 2004) The

state ranked 6th nationally in January 2001 in its proportion of elderly compared to the total U.S. prison population, with 9.9% of Pennsylvania's prison population age 50 years and older. In its absolute number of elderly prisoners, the Pennsylvania system ranked as 7th largest in the United States. (Commonwealth of Pennsylvania Department of Corrections, 2004)

The cost of maintaining older prisoners is nearly triple that of younger inmates, primarily due to health care costs. (Administration on Aging, 2003) In fact, Pennsylvania has built a state-of-the-art geriatric care facility for its infirm prisoners. Nearly half of the nation's state prison systems now offer hospice care for their frailest inmates. (Johnsson, 2003)

Demographic trends and criminal justice policy trends virtually assure that the number of older prison inmates nationally will continue to rise in coming years. The U.S. prison population (all ages) is at a historic high – inflated by 'three strikes you're out' and truth in sentencing laws from the 1980s and 1990s that mandated longer sentences for offenders than they would have served in prior decades. (Trela, 2003) Among the surging population of incarcerated individuals, which now exceeds 2.6 million nationally, are many older people who would have been treated more leniently but for these mandatory sentencing laws and toughened sentencing guidelines which effectively removed virtually all discretion from the sentencing judge. (Hall, 2004)

According to an interview with Dr. Julia Hall, Professor of Sociology at Drexel University and a corrections expert, elderly individuals in the correctional system are functionally older than their chronological age peers in free society – on average by five to 10 years of functional decline. This reflects their life experience during incarceration with poor access to or use of health care, poor nutrition, and unstable, stressful life experience Neglected health conditions among prison populations include dental and mental health, HIV/AIDS, Hepatitis C, and the new, more virulent form of TB. Elderly ex-offenders also have a greater incidence of sexually promiscuous behavior and abuse of alcohol or drugs, including intravenous drugs. (Hall, 2004) Various dementias from alcohol and drug abuse add to the demand for services for the ex-offender. (Hall, 2004) Mental illness is another complicating aspect of the growing prison population: correctional institutions in the U.S. currently house more mentally ill individuals than hospitals and mental institutions. (Trela, 2003)

The other challenging aspect of Pennsylvania and Philadelphia's elderly prison population is their eventual release back to the community. Older ex-offenders have a unique set of needs and vulnerabilities. This may be a particular concern in Philadelphia, which is home to the majority of ex-offenders who will return to the community. However, the concern with this population is not recidivism, which is strongly correlated to age. After age 50, recidivism drops to an extremely low rate for most offenders. (Hall, 2004)

When elderly ex-offenders reenter and reintegrate into the community, they face all of the typical issues faced by older individuals: appropriate, safe and affordable housing,

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mental, medical and dental care and access to prescription drugs, employment or other financial assistance, family and social support. (Hall, 2004)

However, these typical challenges of old age are compounded with legal barriers to employment in some fields, and attitudinal barriers to employment in others, plus a weakened or absent social support system. Elderly ex-offenders typically have lost contact with their families and social network prior to incarceration due to death, relocation and alienation. If some relatives or social contacts have survived, they generally are older or less able or willing to provide assistance to the older person returning from prison. The safety net either doesn't exist or is so full of holes that the older ex-offender is forced to depend on public and private agencies and organizations as their social support system. (Hall, 2004)

There is a need for a 'one-stop' information/referral service for ex-offenders prior to their release to the community – as this information is not readily available. (Hall, 2004) While the needs of ex-offenders may be complex, exceeding the capacity of any single agency, they may not be capable of negotiating the maze of agencies to get necessary services. The organizations whose services may be needed by ex-offenders may include: area agencies on aging, public health services, community mental health services, Veterans Affairs (many are vets), education and job training services, nursing homes, board and care or assisted living, housing agencies and community legal services among other agencies. (Hall, 2004)

The Philadelphia Consensus Group has been studying the reentry and reintegration process. The group has identified the need for attitudinal change within the community as critically important. Despite sentencing guidelines designed to be 'tough on crime, 98%, of incarcerated people will return to the community. (Hall, 2004)   Employers, service providers, senior and nutrition centers and places of faith need preparation to respond appropriately to this challenge. (Hall, 2004)

The unique needs of ex-offenders may become a greater public concern if a recent piece of federal legislation, known as the Jackson-Lee's Federal Prison Bureau Nonviolent Offender Relief Act becomes law. (Johnsson, 2003) This bill was not enacted prior to the publication of this report. However, if this or similar legislation is ever passed, it would free federal inmates 45 and older if they were nonviolent offenders who had served at least half of their sentence and did not break prison discipline rules.

If this or similar legislation is passed, a resulting influx of individuals into the general population (who may have significant medical, psychological or other problems as a result of their years behind bars) would pose new challenges for the health care, mental health and social service systems.

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V.   Conclusion and Next Steps

This report is about the future of our community's grandmothers and grandfathers, aunts and uncles, mothers and fathers, friends and acquaintances. And it is about whether they will be cared for with the level of compassion and kindness that characterizes a civilized society. This report may also provide us with an opportunity to prepare for the next cohort of the aging population.

Cloaked in the pages of this report are lives that will unfold. Whether the stories of Philadelphia's future elderly population, on balance, will end in sorrow or fulfillment depends in large part upon the political will, creativity and determination of the many individuals, organizations, politicians and communities who will be affected by their presence.

Many of the community leaders on aging interviewed for this report have a broad vision for a brighter outcome for Philadelphia's elderly population – but only if current and anticipated problems are addressed in new, creative ways. This vision includes the following:

- "Healthy aging" in which the elderly are viewed and used as an asset in their community, and in which the community, in turn, makes changes large and small to facilitate older individuals' physical, mental and spiritual health.

- Community-based planning in which a community assesses the needs of its entire population from birth through death, identifying and addressing commonalities of needs including (but not limited to) well-maintained sidewalks and extended walk times at cross-walks that would help both children and the elderly, respite services for caregivers of both the elderly and disabled populations, schools that involve seniors as volunteers while also offering them continuing education, and recreation centers that serve schools, neighborhoods and the elderly.

- Restructure opportunities for employment and volunteerism to enable the elderly to play a productive role in society.

- Educate the region's current and future elderly so that they are empowered to cope with a range of issues associated with old age, such as how to access available services (from pertinent public and private sector organizations), the need for financial and legal planning, the need to plan in advance for transportation and household accessibility needs. Consumer focus group participants cite the particular need for information about health care, prescription medication plans, Medicare and supplemental insurance benefits. Public awareness campaigns can encourage older adults and their families, particularly those from ethnic and minority groups, to use aging-related services.

- Evaluate the shift to community-based care in terms of how it creates new vulnerabilities for the elderly and their families and caregivers and take steps to protect the elderly from negative outcomes – or when appropriate, restructure the delivery of community-based care.

- Confront issues, challenges and consequences associated with health care reform, mental health care reform, and Social Security reform.

- Restructure access to public and private sector benefits so that the application and qualification process is more readily understood by the elderly; and so that they are protected from arbitrary disqualification by battling bureaucracies or rationing of services.

- Prepare the workforce so that it is well-equipped to respond to the aging population in terms of sheer size and diversity.

- Take an interdisciplinary approach to aging in place issues i.e. include planners, real estate developers, mental health professionals, architects, hospitals, PCA, etc.

As public spending on the least fortunate in society continues to contract, wise use of the funds that are allocated to the elderly population becomes even more important. It is hoped that this report can translate into cooperation and collaboration, rather than political competition, among the many public and private sector organizations that serve the elderly – so that these funds can be leveraged for the greatest possible benefit of current and future elderly generations to come.

Insights from Community Leaders

There is no one single solution for the multiplicity of challenges ahead. But a survey of possible best practices from community leaders could be a useful starting point.

Ask Consumers What They Want and Need

"The aging community needs to talk to the seniors and ask 'What do you want? What do you need or desire to achieve your life goals? What is bothering you and what should we do about it?' We need to really find what is on people's minds and not assume that we know what they need."

"If we took the steps to understand what people really want, we might still have this whole array of services for people who need them. Then again, there might be fewer or different tiers of services or different programs altogether. Or perhaps people are content with some things that we think people are bothered about. We just don't know."

"I'd like to see more opportunity for dialogue with non-professional people who do not spend their lives worrying about medical models and funding. We need to figure out how to have regional and national dialogue about what people's needs are and will be."

"Talk to the seniors and not just those at the senior centers. Ask: 'What do you need now, and what will you need in 10 years?' Talk to the 75+ group, who will be 85+ in 10 years. Don't assume you know what they need. Pay them for their time."

Advocacy and Coalition-Building

"We have to impress upon policymakers and elected officials that now we need to take this whole demographic trend seriously, make it part of how services are delivered, and structure it so that it is part of city government in a more important and responsible way. We need to alert people to upcoming demographic changes, form coalitions and unite around needed funding for this population. We should continue to advocate on the systemic level at the city, state and federal level, fight the cuts we are anticipating and advocate for laws that are advantageous for older adults."

"We also need to educate the community, put issues on the table and really demand that people in positions of power respond. As part of this advocacy effort, we need to make communities more aware of the issues. We should hold a local summit on aging, like a National Council on Aging conference, but more localized. Bring people into a public setting to talk about aging – for example, aging and housing with city officials, realtors, hospitals, etc. present."

"Communities have to be more politically aware. That's the first step. The only way change will occur is if seniors become more politically aware and voice opinions about what is going to happen. The baby boomers right now are so busy raising their kids and being soccer moms that they're not yet into volunteering to work in the communities. I think people are going to have to start taking some action."

"Coalitions should be formed and united around needed funding for the population. With coalitions, it's the power of the people. It affects our parents, it could affect us and it could affect you. So it is something that crosses all political lines, gender lines, sexual orientation lines. We are in a hard time, so people need to look to each other for a solution. We need to find ways to work together, probably in areas where we haven't come together to assess similar problems. We need to help one another and make Philadelphia a better place."

"In the Asian community, people are starting to become more politically aware. They want to have the power to make things better. For example, they are joining forces with organizations such as AARP, forming a lot of their own groups, and getting outside of their community and into the main stream of America. The Hispanic community is going to do the same thing and that's the only saving trend I can see – that after people are in the country for a while, they are going to take more control of their surroundings."

"Get out of the aging box and look beyond what is traditionally being defined as aging service agencies' role. We're all so territorial, but it's difficult to have a mission just to do this aging delivery program only. I think the times dictate that you have to be a lot broader than that."

Improve Service Coordination and Build Partnerships

"Coordination is lacking. Aging and mental health agencies don't always talk well because they are competing for the same funds or they have a different philosophy. But they should be working collaboratively. There is plenty of business for all of us. Getting people together to talk and hash out issues is really important. We need to work and talk together better to get things done. Many times this system mitigates against that."

"We want to develop more comprehensive aging-related training for the network, in terms of looking at different programming and reinforcing the same notions over and over again until it becomes a part of their ongoing thinking as opposed to a new idea."

"People tend to react as opposed to planning. Even if the best plan is laid out, people will continue to do what they are doing until they are forced to make a change. The most we can do is to help people prepare for that inevitable moment when they have to change."

"I hope that ten years from now there will be lots of collaborations where aging is always at the table when we are talking about neighborhood development, and when we are talking about school issues. Schools seem to think they have a life-long commitment to learning, and so do the universities. But the aging community also has a commitment to other generations, and that is not necessarily the philosophy of the aging network or PCA right now which is to [exclusively /or/ primarily] focus on older people."

Establishing partnerships with academic centers would be good – to use them as a resource, to enhance services, credibility, and reputation.

Incorporate Aging into Public and Private Sector Planning

"We need to get out of our old boxes and have the aging network be more fully integrated into the rest of what happens in Philadelphia. I don't think it is now. It is very separate, focused – and understandably so – on the needs of older people. However, as a result, I don't think the whole community understands the challenges and opportunities of our changing demographics. We should involve people beyond the aging network and try to come up with solutions together."

"There are ways to integrate aging-related issues when you are making capital investments and longer-range planning so that you anticipate what the needs are. Taking the elderly population's needs into account doesn't have to be prohibitively expensive; and is important for both public and private sector planning. It could mean, for instance, how long the walk signals last on traffic lights, or the size of the print in city documents. Aging-related needs ought to at least be part of the thinking so that we anticipate this and don't wake up some day and say, 'Oh, my God!' The whole concept of age-sensitive communities is something that PCA may have a responsibility to promote."

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"The Chicago city government has institutionalized aging issues in every department of the city. There is a designated person in every department of the city who is focused on how to make communities age-sensitive. Even the Department of Sanitation has somebody in its department who is designated to look at the needs of older people. That is a remarkable model. I don't know how Chicago plays that out on a day-to-day basis but the concept and construct of it just sounds absolutely like genius. If the city of Chicago can do something like that, certainly the city of Philadelphia which is very similar in terms of neighborhood structure could do the same."

"Everyone is thinking quarter-to-quarter, particularly on the service delivery side but even at phone companies, power companies and city government. When you think quarter to quarter and you think in terms of short term investments, it may be entirely appropriate. But if you can do it with a longer range vision of where you are going and at least have that be part of the planning process, there is a greater benefit."

"For instance, if you are going to spend a billion dollars constructing new school facilities and you are also looking at the population changes that are occurring in this city, and if you think about the useful life of building such as schools, it would not hurt to construct so that it works as a school and also to anticipate it as a dual-use facility and eventually have it convert into to a senior center if the demographics of this city continue to evolve the way they have evolved. I don't know that people are thinking that way and even asking these types of questions."

Another example of the benefit of thinking collaboratively to address aging-related issues: the School District of Philadelphia is about to undertake close to a billion dollar capital development program. At the same time, City of Philadelphia recreational facilities are being closed. In many cases, these recreational facilities are near schools. In planning those facilities, one question is, could the school facilities basically be planned as future senior centers."

"There is a big disconnect between the way policies are decided – older people are not in mind when policies are made. Policy-makers need to evaluate what healthy aging looks like in a big urban area, and how can we help foster this?"

"Just think of the size and impact of the group that's going to be in retirement ten years from now. It will require all levels of government to be adept and knowledgeable about this population. It is a huge market sector. Some companies are savvy, and are beginning to concentrate on how they provide services to them but by and large the rest of the economy is not paying much attention to it."

Strategic Planning

"If we start planning now it could probably be done less expensively than if we wait until the problem is upon us. This would be an evolutionary process as opposed to a revolutionary process."

"We need a short-term plan and a long-term plan. We need a working document that develops short- and long-term strategies around issues that are emerging. This strategic document should anticipate needs and issues and get political leaders, politicians and other government folks thinking about ways to work together to implement solutions. This would help people design systems or programs and enable them to work with the state and in particular with the Rendell administration, to try to design programs and policies that build the foundation for dealing with the anticipated needs of Philadelphia's aging population."

"Planning for ten years from now doesn't have to be an independent exercise. It could be integrated into annual planning activities in which we look two, five and ten years ahead. Of course, there will be unanticipated changes. But we should evaluate whether our path for the next two or three years is consistent with where we ought to be in ten years."

Educate Consumers

"Make sure that important information is communicated in a meaningful way. The amount of information is voluminous and not easily digestible by people in the field and consumers. I think the dissemination of information and the communications are some of the biggest weaknesses of our programs. Not just in the new immigrant community but in other communities where people don't fully get the message of what services and supports are out there. For example, right now there is a lot of confusion over Medicare cards and prescription drug cards. Nobody knows what is going on."

"We need to educate people who are not using the aging services system on how it works. This includes those who will use it in the future."

Facilitate Neighborhood-Based Planning

"Encourage people to be more tuned in to what is going on in their community. Community organizations that meet and work together can save a city. Communities need to understand the demographic trends, take the statistics as they exist now, the projections on what we need to have and how we need to prepare for future trends. We should foster neighborhood dialogue about those changes. Some neighborhoods are changing now. We ought to integrate our older residents into the fabric of the community by 2015."

"We should focus on pilot projects in particular neighborhoods. When you think about what the community of Philadelphia could do to support people as they age versus at a point in time, a lot of this is geographically based – working on neighborhoods and working together. The aging network could be the leader in this versus sitting back and again being so overwhelmed by 'we are going to have so many older people; and we don't have enough money for services.'"

"On a local level as well as on a systems level that Department of Human Services and Housing and Disability and all these different groups – the youth people, the housing

people, the environmental people, the disabilities people, the immigrant community, etc. – should be working together to look at how do we make this place better for people. There are just so many commonalities. There are so many things that could be done if people feel a commitment and responsibility to each other. But as long as these people go here and these people go there and this system only deals with old people and this other system only deals with young people and they never talk, I just don't see much hope."

Members of communities need to be made to feel responsible for each other because no service agency will be able to meet all of a person's needs. This has to be done through a community organizing model. There is a tendency to rely on formal type services through the aging network. But there's not enough attention paid to all of the other resources in a community such as a church that is willing to do some shopping for people, a neighbor, that sort of thing. We need to start looking at those types of resources as valid resources."

"Philadelphia is still a city of neighborhoods. I am intrigued about the potential for smaller niche initiatives that could be very effective. The issues in the northwest are different than in the northeast. It has different populations, different housing stock, and different resources are available. A model project could pilot needed services for a particular section of the city. There probably should be some focus on education, some focus on healthcare delivery, insurance, Medicare, Medicaid, some focus on the payment side and some focus on working with providers."

Community Assets

"Younger retirees are getting involved, which is really promising, and we see them in other organizations at 60, 62, 65. They are now beginning to experience the issues so they are going to be leading the pack of what is coming behind and surprisingly enough the group is really good. They have new ideas on how to confront issues, a lot of energy and the time to do it. They are really going to be trained and prepared to help people ten years down the road. So that is promising."

"The Philadelphia community also has new forms of organizing using the Internet."

"Philadelphia has a good aging network and that can work in favor of older Philadelphians. Good people doing good work on behalf of older Philadelphians. We are fortunate to have all kinds of agencies serving this population, a decent public health system in the city, and the PACE[1] program (Pharmaceutical Assistance Contract for the Elderly)."

[1] PACE (Pharmaceutical Assistance Contract for the Elderly) is a prescription coverage program for Pennsylvanians age 65 and older, whose income is $14,500 or less. In the program, generic prescriptions will cost the consumer a co-pay of $6 and $9 for brand names. The program is funded by the Pennsylvania Lottery and is administered by the Pennsylvania Department of Aging.

Barriers to Planning Ahead

"We are busy doing rather than planning. We try to participate in that stuff given our limitations but our focus is really on delivery rather than planning. We sometimes have a 5 year strategic plan in place and that's usually very ambitious and we might achieve a number of the things but it is not a rigid process probably no where near as rigid or formal as what PCA is doing and I think it is good to plan for the future but I think it is a luxury. So, it's hard."

"There is a very real tension between present versus future needs when a lot of organizations are operating on a shoestring. The time required to deal with immediate priorities always seems to take priority over planning for the future. Everybody is so busy with the work at hand. It's difficult to see ahead and act and react to what needs to be done.

"Our plates are full reacting to what is happening today. We have limited resources for planning and investing in the future."

"Uncertainty is woven into our planning as advocates."

"We are living in very conservative times and I don't see any radical turnaround. How we are going to respond to the needs in our present financial social service structure? I'm not sure. Aging is not a high priority. Even within the social service system I look at the focus and the elderly I don't think are too high up in the hierarchy right now. We really are not a high priority."

"The fiscal environment is not promising over the next 10 years with the war and a huge, problematic federal deficit."*

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Appendix

Philadelphia Community Leaders Interviewed for the Report

<u>Individual Interviews</u>

Emily Amerman
Executive Director
LIFE
Philadelphia, PA

Christine Arenson, M.D.
Board Chair,
Philadelphia Corporation for Aging
Clinical Assistant Professor and Director of Geriatrics
Jefferson Medical College
Department of Family Medicine
Philadelphia, PA

Arlene Bailey
Social Services Program Supervisor
Office of Emergency Shelter and Services
Philadelphia, PA

Mary Bell
Principal Regional Analyst
Delaware Valley Regional Planning Commission
Philadelphia, PA

Kevin Breazeale
Deputy Director
Office of Emergency Shelter and Services
Philadelphia, PA

Tiffany Brewington
Personnel Manager
Philadelphia Corporation for Aging
Philadelphia, PA

Toni Clemmons
Director of Program Management
Philadelphia Corporation for Aging
Philadelphia, PA

Helen Cooke
Assistant Director, Health and Nutrition
Philadelphia Corporation for Aging
Philadelphia, PA

Kathy Cubit
Director, Advocacy Initiatives
The Center for Advocacy for the Rights and Interests of the Elderly (CARIE)
Philadelphia, PA

Susan Denman, M.D.
Medical Director
Evercare Philadelphia
Horsham, PA

Thomas Earle
Executive Director
Liberty Resources, Inc.
Philadelphia, PA

Deborah Frazer, Ph.D.
Geropsychologist
Philadelphia, PA

Pat Funaro
Assistant Director, Program Management
Philadelphia Corporation for Aging
Philadelphia, PA

Florence Gallagher
Board Member, Philadelphia Corporation for Aging
Philadelphia, PA

Pearl Graub
Director of Professional Services
Philadelphia Corporation for Aging
Philadelphia, PA

'Dolph Greenberg
William Way Lesbian, Gay, Bisexual and Transgender Community Center
Philadelphia, PA

Julia Hall, Ph.D.
Coordinator, Criminal Justice Program
Culture and Communications
Drexel University
Philadelphia, PA

Nancy Henkin
Executive Director
Temple University Center for Intergenerational Learning
Philadelphia, PA

Carole Irvine
Vice President, Health Care Services
Albert Einstein Healthcare Network
Philadelphia, PA

Jean Janik
Director, Community Living Options
Philadelphia Corporation for Aging
Philadelphia, PA

Kevin Jones
Chief Executive Officer
Inglis House
Philadelphia, PA

Joan Klein
Director, Family Caregiver Support Program
Philadelphia Corporation for Aging
Philadelphia, PA

Susan Klein
Director of Housing
Philadelphia Corporation for Aging
Philadelphia, PA

Daniel Lyons, MD
Senior Vice President, Government Programs
Independence Blue Cross
Philadelphia, PA

Maureen McKoy-Farmer
Associate State Director
American Association of Retired Persons
Philadelphia, PA

Betsy O'Brien
General Counsel
The Wistar Institute
Philadelphia, PA

Maxine Ohringer
Shelter Services Administrator
Office of Emergency Shelter and Services
Philadelphia, PA

James Pezzuti
Director, Long-Term Care Client Services
Pennsylvania Department of Public Welfare
Harrisburg, PA

Sandy Pfeffer, Esquire
General Counsel
Philadelphia Corporation for Aging
Philadelphia, PA

Ray Polak
Director, Human Resources
Philadelphia Corporation for Aging
Philadelphia, PA

Pedro Rodriguez
Executive Director
Action Alliance of Senior Citizens of Greater Philadelphia
Philadelphia, PA

Barry Seymour
Assistant Executive Director for Regional Planning
Delaware Valley Regional Planning Commission
Philadelphia, PA

Michael Smith
Executive Director
Philadelphia Developmental Disabilities Corporation/Arc
Philadelphia, PA

Rick Spector
Director, Community Relations
Philadelphia Corporation for Aging
Philadelphia, PA

Steve Touzell
Deputy Director, Long-Term Care
Philadelphia Corporation for Aging
Philadelphia, PA

Tom Volkert
Director, Mental Health and Aging
Mental Health Association of Southeastern Pennsylvania
Philadelphia, PA

Skip Voluntad
Chair, Asian Advisory Council
Philadelphia, PA

Pam Walz
Supervising Attorney
Community Legal Services
Philadelphia, PA

Andrew Wigglesworth
President
Delaware Valley Healthcare Council
Philadelphia, PA

Celeste Zapalla
Executive Director
Mayor's Commission on Aging
Philadelphia, PA

Group Interviews

Faculty of the Hartford Center for Geriatric Nursing Excellence, School of Nursing,
University of Pennsylvania. Professor Neville Strumpf, Director

Asian Advisory Group, Philadelphia Corporation for Aging

Latino Advisory Group, Philadelphia Corporation for Aging

Housing Advisory Group, Philadelphia Corporation for Aging

Philadelphia Corporation for Aging is a non-profit organization established in 1973 to serve as the Area Agency for Philadelphia. Its mission is to improve the quality of life for Philadelphians who are older or who have disabilities and to assist them in achieving optimum levels of health, independence and productivity. PCA receives its funds, in part, from the Older Americans Act, Medical Assistance and the Pennsylvania Lottery all through the Pennsylvania Department of Aging.

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