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STATE OF NEW JERSEY

County and Municipal Government Study Commission

SERVICES FOR THE ELDERLY: CURRENT AND FUTURE NEEDS

October 1988

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GOVERNMENT STUDY COMMISSION

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TO HIS EXCELLENCY GOVERNOR THOMAS A. KEAN AND HONORABLE MEMBERS OF THE SENATE AND GENERAL ASSEMBLY:

The County and Municipal Government Study Commission is pleased to submit its thirty-eighth report, *Services For The Elderly: Current And Future Needs.*

This report constitutes an in-depth examination of the status of New Jersey's elderly and the governmental programs in place to address their needs. The elderly form the fastest growing segment of New Jersey's population, presently encompassing over one million of the State's inhabitants. As such they comprise one in eight of New Jersey's total population. In speaking of New Jersey's senior citizens, it should be noted that they do not constitute a homogeneous group. Rather, they differ greatly in socio-economic circumstances and health conditions.

Several overlapping substrata of New Jersey's elderly stand out as in need of governmental attention. The most notable of these are the *older* elderly—those over 80, experiencing the frailties of old age, and thus most in need of medical and supportive services. Another significant subgroup are unattached elderly women. The current differentials in life span and income between men and women leave large numbers of these women at the edge of or in poverty. The problems of poverty are also much more prevalent among elderly Hispanics and blacks.

The Commission, in its investigation, found that different kinds of services were provided for the elderly by different levels of government, with shared responsibilities existing in select policy areas. County government is a major agent for administering elderly programs, particularly the *County Offices on Aging.* New Jersey Government plays a major role in funding health and welfare services. A large portion of New Jersey's Medicaid expenditures is for the elderly. State government garners money from casino industry operations that is earmarked for programs aiding the disabled and senior citizens. The *Casino Revenue Fund* presently provides approximately $250 million a year. The Federal Government plays an important role in providing an income and health safety-net for the elderly through its Social Security and Medicare programs.

In reviewing the panoply of programs in place, the Commission identified various areas of elderly need. Two, in particular, stood out as warranting greater governmental attention: *health care* and *housing.* Within health care,

the major gap concerns the provision of long-term care. To rectify the deficiencies in long-term care, which largely concern too great a focus on institutionalized care, the Commission recommends the establishment of greater numbers of lower-level care facilities, and community and home-based services, and the establishment of a comprehensive system for placing individuals in the appropriate level of long-term care. The Commission also recommends that the State act to encourage the development of private and publicly-based long-term care insurance coverage for New Jersey residents.

In the field of housing the Commission has several recommendations, all of which are designed to procure fuller use of the existing housing stock. These include the encouragement of home equity conversion plans, greater use of home-sharing, and the expansion of the home repair program for low-income elderly.

The adoption of these recommendations should ameliorate the lives of many of New Jersey's elderly who are in need.

Respectfully submitted by the members of the County and Municipal Government Study Commission.

/s/ Carmen A. Orechio, Chairman
/s/ John A. Lynch Jr.
/s/ Henry P. McNamara
/a/ Rodney P. Frelinghuysen
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Particular mention needs to be made of those offices within New Jersey's *area aging* network, the *County Offices on Aging* and the State's *Division on Aging.* Within the Division on Aging, we would like to give special thanks to Ann Zahora, Executive Director, for her sympathetic aid. Of the Division on Aging's able staff, we would like to thank Theresa Dietrich, Mary Bentivegna, Cindy Flynn, and Alice Obelliero for their advice and technical support.

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We also wish to note the participation of the many individuals, too numerous to mention, from the various county social service and welfare boards and departments, non-profit organizations, and municipal officials throughout New Jersey whose ample assistance enabled us to familiarize ourselves with the intricacies of service-delivery at the local level.

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EXECUTIVE SUMMARY

THE GREYING OF NEW JERSEY

The post World War II period has witnessed a pronounced greying of New Jersey's population. The elderly,* the fastest growing segment of the State's citizenry, presently make up one million of New Jersey's inhabitants. Particularly prominent is the growth in the numbers of elderly over 75 years of age—those most likely to be in need of health and social services.

In examining the situation of New Jersey's elderly, it is important to bear in mind that senior citizens constitute a heterogeneous grouping. However, while there are wide variations in income, health, and social circumstances, there exist segments of New Jersey's elderly population whose shared condition warrants government attention. Salient among these subgroups of the senior population are the *older* elderly—those experiencing the frailties of old age and thus most in need of medical aid and supportive services. Another major subgroup are single, elderly women. Given the differentials in life span and income between the present generation of men and women, unattached elderly women find themselves at the edge of or in poverty in much greater numbers than their male counterparts. In addition, higher percentages of elderly Hispanics and blacks live out their lives in poverty.

The majority of New Jersey's elderly are located in the eight counties adjacent to New York City and Philadelphia. In seven of New Jersey's counties, more than half of their population increase is due to the growth in elderly population. Another phenomenon of import is the greying of New Jersey's suburbia. Those suburban areas populated by young married couples in the years immediately after World War II are experiencing increasing numbers of that generation now reaching the retirement years. Given the propensity of seniors to remain in their neighborhoods of residence, this residential aging pattern suggests a growing need for services in those suburbs with aging populations.

THE FEDERAL AND STATE ROLES IN PROVIDING SERVICES FOR THE ELDERLY

Federal Role

The needs of the elderly are addressed by Federal, State and local units of government. The Federal Government has played a crucial role in establishing a safety-net for senior citizens, particularly in the areas of income and health, through the enactment of Social Security and Medicare. Over time, these two policy areas have served as the bedrock of Federal efforts. Recent actions have extended Federal endeavors in the provision of social services.

*By *elderly*, in this Report, we mean the population age 65 and over.

In addition, many programs targeted at the nation's low income population have aided substantial numbers of senior citizens.

Senior citizens' share of the Federal budget is about 28 percent, with present outlays around $270 billion a year. The former figure represents roughly a doubling of the elderly's share of the 1960 Federal budget, which was approximately 15 percent of total Federal expenditures. The biggest rise in Federal expenditures for the elderly has been in the health care field. Recent data indicates that combined Federal expenditures on Social Security and Medicare amount to over 75 percent of total Federal outlays for the elderly.

Recent actions have extended Federal provision of social services for the elderly. Chief among these are the Older Americans Act programs which offer a departure from previous programs in that they seek to institute a coordinated and comprehensive service system for the elderly. Funded by Federal monies and overseen by the Administration on Aging at the national level, the Older Americans Act entails a partnership between Federal, state, and county governments in providing services for senior citizens. Within New Jersey, Older Americans Act programs are operated by each of the 21 counties.

State Programs

New Jersey has made a major effort to aid its elderly. State funded programs for the elderly in 1985 reached expenditures of $450 million with over 70 percent of total elderly spending going for health and welfare services. Estimates for 1989 are for expenditures of about $700 million. Of New Jersey total Medicaid expenditures of $1.2 billion in 1987, $430 million went for nursing homes, the vast majority of which are for the elderly. One of the most significant, recent trends in New Jersey is Medicaid's underwriting of home and community-based care.

Within New Jersey, the State's Division on Aging oversees the county-based provision of elderly services. The Division's establishment in 1957 made New Jersey the first state in the Union to have a state agency exclusively focusing on matters concerning the elderly. The Division's primary role is to coordinate Older Americans Act programs.

Various programs for the elderly are financed by the State's Casino Revenue Fund. The two largest programs are the *Lifeline Credit-Tenants Assistance Programs* ($63 million) and the *Pharmaceutical Assistance to the Aged and Disabled Program* ($41 million). *Lifeline*, which has income eligibility requirements, provides a $225 annual credit for combined gas and electric utility expenses. *Pharmaceutical Assistance to the Aged and Disabled*, with similar income eligibility requirements, pays for the individual's cost of a prescription drug after a participant's co-payment of two dollars. *Lifeline* has over 300,000 households eligible for the program, while *Pharmaceutical Assistance* has about 225,000 New Jersey residents presently served by the program.

GOVERNMENTAL PROGRAMS FOR THE ELDERLY

FEDERAL

Social Security
Medicare
Supplemental Security Income

STATE

Lifeline-Tenant Assistance
Pharmaceutical Assistance to the Aged and Disabled
Community Care for the Elderly and Disabled
Property Tax Deduction ($250 per homeowner)
Subsidized Housing

COUNTY AND MUNICIPAL

Nursing Home Care (County)
Community Health Services (C&M)
Mental Health Services (C&M)
Adult Educational Programs (C&M)
Library Services (C&M)
Parks and Recreation (C&M)
Subsidized Housing (C&M)

INTERGOVERNMENTALLY SHARED PROGRAMS

Medicaid*
Older Americans Act Programs**
- Home-Delivered Meals
- Congregate Meals
- Adult Day Care/Respite Care/Caregiver Support Groups
- Home-Sharing
- Protective Services
- Senior Health Care Insurance Program (SHIP)
- Transportation Services
- Information/Referral/Outreach Services
- Homemaker/Home Health Aid Services
- Chore Maintenance Services
- Visiting Nurse Program
- Community-Based Health Services
- Legal Services
- Residential Repair and Housekeeping Services
- Escort Services
- Educational and Recreational Programs
- Retired Senior Volunteer Program (R.S.V.P.)
- Language Translation Program

Energy Assistance
Subsidized Housing*

*Federal and State operated programs
**Federal, State, and locally operated programs

ROLE OF NEW JERSEY LOCAL GOVERNMENT

The major administrative responsibility for elderly services lies with county government. As the focal point of service-delivery, county government constitutes the major point of contact between government and the State's senior citizens. This role is a logical one, given the county's extensive experience with administering social programs and its physical proximity to the population it serves. In addition, numbers of municipalities provide services for the elderly.

County Offices On Aging

Within county government, the primary role in ensuring and coordinating the delivery of services for the elderly is played by the *County Office on Aging*. Each of New Jersey's 21 counties has such an agency. For the most part, these organizations do not deliver services. Rather, they contract to nonprofit organizations and other providers who furnish the services. In 1987, county monies for Older Americans Act programs came to about nine million dollars, with the State share a bit over one million dollars, and the Federal share for New Jersey over $21 million. In addition to the basic set of programs handled by the *County Offices*, numbers of *County Offices* have innovative programs indigenous to their own counties or operated by a small number of counties.

The major functions performed by the *County Office on Aging* include providing: *access services*, *nutrition services*, and *home and community support services*. The "access" role entails identifying eligible senior citizens, informing them of available services, and assisting them in ensuring that the service is received. The most important substantive program is undoubtedly that of *nutritional services*. The "home-delivered meals" program, which provides at least one hot meal daily to seniors who are homebound or incapacitated, serves over 18,000 elderly a year. The "congregate meal" program, which provides meals to seniors in institutional settings, serviced 44,000 senior citizens in 1987.

Other County Agency Roles

Numbers of other county agencies play vital roles in serving the elderly. They provide a wide assortment of services which run the gamit from welfare and human services, mental and physical health care, educational offerings, nursing home care, to recreational programs and legal counseling. The county costs per individual service range from under a thousand dollars to hundreds of thousands of dollars in the most populated counties.

Several agencies stand out because of the importance of their roles. Among them are *Welfare Boards and Boards of Social Services*, which determine eligibility for certain Federal, State and county welfare programs, and provide cash assistance and social services for the needy. Specific programs, operated by such boards, which aid the elderly, include: the *Food Stamp Program*, *Adult Protective Services*, the *Home Energy Assistance Program*, the *Homemaker Program*, the *Sheltered Care Program* (placing low-income

people in the proper housing facility), *Medical Transportation* (providing transportation to medical facilities for those in an emergency situation or those without the ability to get to medical facilities), sheltering and other services for the homeless, and the *Community Care Program for the Elderly and Disabled.*

One of the most important and expensive services provided by county government for the frail elderly is that of nursing home care. Twenty-two county nursing homes presently are in existence, with 18 counties having such facilities. They service more than 4,000 patients on a daily basis.

County and Municipal Functions

Several kinds of benefits are provided to the elderly by both county and municipal governments. Health departments at both the municipal and county levels provide services whose clients include the elderly. The service focus, here, is on screening, referrals, and counseling. Many county health departments have special health assessment programs for older adults. Another service, that of mental health, is operated by each of the 21 counties' mental health boards as well as numbers of municipalities. Counseling and social services are provided for those with mental problems.

Other important areas in which counties and municipalities provide services utilized by the elderly are those of educational and library services. County community colleges and county and municipal public schools operate adult courses which are taken by good numbers of seniors. Municipalities and some counties provide senior citizen housing through local housing authorities. Both counties and municipalities have public libraries of which senior citizens are major users. The same holds true for parks and recreation departments.

RECOMMENDATIONS

While great progress has been made in meeting the needs of New Jersey's elderly, vital gaps still exist. The Commission found two areas, in particular, in need of amelioration: ***gaps in health care provision*** and ***gaps in adequate housing for low-income elderly individuals.*** The Commission's recommendations are designed to improve the situation in both of these areas.

Long-Term Care

Within the health care field, the major gaps are in the adequate provision and financing of long-term care. One of the noteworthy problems is the existing bias in the system in favor of institutionalized long-term care. This has had two deleterious effects: 1) it has placed significant numbers of elderly in more intensive care than is necessary at much higher cost than is required for adequate long-term care, and 2) it has hampered the growth of lower level care facilities, and home and community-based services. Therefore, the Commission recommends that the State of New Jersey reorient its long-term care services toward greater provision of lower level institutional, community and home-based care:

Recommendation I: New Jersey act to establish a more cost-efficient system of long-term care by encouraging the establishment of a greater numbers of lower level care facilities, and community-based and home-based care services.

Restructuring of long-term care services to achieve greater coordination and cost-effectiveness requires the use of administrative mechanisms that match the individual with the most appropriate level of service. Doing so would lead to a more coherent and integrated system of long-term care.

Recommendation II: The Commission recommends the establishment of a county-based administrative process for the appropriate placement of individuals in the continuum of long-term care.

While State operated, long-term care service exist for the indigent and near-poor, middle class seniors are left to fend for themselves. The State should also play a role in aiding the financially solvent elderly. It is important to bear in mind that over 40 percent of elderly out-of-pocket, medical expenses are for nursing home care. The thrust of State policy toward the financially secure should be directed at encouraging the establishment of insurance mechanisms that involve risk-pooling. Toward this end, the Commission recommends the following:

Recommendation III: The State act to establish long-term care insurance coverage for its employees as part of their retirement benefits.

Recommendation IV: New Jersey State and local government encourage corporations to establish post-retirement long-term coverage for their employees.

Recommendation V: New Jersey should encourage a non-profit association to establish voluntary insurance coverage for long-term care for the general population.

Recommendation VI: New Jersey State and local government encourage the corporate sector to make available adult care for the parents of their employees.

As a complementary approach to risk-pooling we recommend:

Recommendation VII: The Commission encourages the effort to have the elderly provide volunteer long-term care for future service credit.

Adequate Housing for the Elderly

Adequate housing is another major area of senior citizen need. With the Federal Government's diminishing involvement in subsidized public housing, the problem of housing for the low-income elderly has intensified. For a stratum of the elderly, income diminishment after retirement weakens their financial capacity to retain adequate housing. There are several measures which government can undertake to ameliorate the housing situation. One partial solution is greater use of "home-equity conversion"—the use of the

equity in one's home to generate income without having to vacate one's property.

Recommendation VIII: New Jersey should provide the regulatory framework and the public educational support that would enable the private sector to popularize the use of home equity conversion plans.

Also, greater effort can be made at home-sharing under conditions advantageous to both the homeowner and the tenant. Such an effort would be directed at utilizing existing housing rather than expanding the housing stock. Toward this objective, the Commission recommends two measures. One entails establishing a *housekeeper program* whereby a family would provide room and board to an elderly individual in return for the ongoing performance of agreed upon household chores. The other entails effort at expansion of the *home-sharing program* whereby elderly homeowners, in need of additional income and/or companionship, are matched with an individual seeking housing of modest rental expense.

Recommendation IX: The Commission recommends public encouragement of two kinds of efforts. One entails establishing a "housekeeping program." The other entails encouragement of the existing "home-sharing program."

To further aid low-income elderly homeowners, the Commission recommends an expansion of the existing *home repair program.* The focus of the program would be on utilizing high school vocational students.

Recommendation X: The home repair program for low-income elderly homeowners should be extended to include assistance by high school vocational students.

This report concludes with a final recommendation in the area of job placement. Given the desire of many seniors to engage in part-time or temporary work, the Commission recommends greater county effort to facilitate job placement. Though job placement programs exist for the low-income elderly, there is no formal State-wide program for those not low income. Thus the Commission recommends:

Recommendation XI: County government should be encouraged to develop job placement programs for senior citizens above the poverty level. The emphasis should be on job placement in the private sector.



CHAPTER I
DEMOGRAPHICS OF THE ELDERLY POPULATION

INTRODUCTION

The failure of the Sixteenth Century Spanish explorer, Ponce de Leon, to discover the Fountain of Youth left New Jersey, along with its sister states, with the requisites of a future elderly policy problem. Given the social and economic developments of the past few decades, the need to address the problems of the elderly has grown. Several advances have led to a prolongation of human life and thus to a larger elderly population: improvements in medical technology, better home heating in winter and cooling in summer, an abundance of food, and increased knowledge of diseases and well-being. These developments have also produced greater exposure to the frailties of old age.

All levels of government have been active in addressing the needs of the elderly. The national government, in creating the Social Security system, established a safety net for the retirement years. This was followed, in the 1960's, by the enactment of Medicare—a system of financial support for basic medical services for senior citizens. The past couple of decades have witnessed further Federal initiatives, under the Older Americans Act, to provide a broad array of community based services that involve the participation of state and county governments.

Counties, in traditionally performing general welfare and health functions for the indigent, have historically included among their clients the needy elderly. Current trends in the State of New Jersey have entailed a substantial increase in the county role of overseeing service provision for senior citizens. Much of the county role arises out of a joint intergovernmental system, made up of Federal, state, and county government institutions, designed to address the needs of the elderly population.

This report focuses on the role of New Jersey counties and municipalities in addressing the needs of the elderly within the State. Of the two, the county role is paramount in attending to elderly needs. To comprehend the role played by New Jersey county government, however, it is necessary to understand the overall system of governmental responsibilities for elderly programs of which New Jersey county governments play a part. Much of what the counties of New Jersey do is connected to Federal and New Jersey Government purposes and financing.

As part of the nation, New Jersey is entangled in the country's overall economic and social condition. Fluctuations in the business cycle and employment, population inflows or out-migration, growth or contraction of the housing market, all have a bearing on New Jersey's social circumstances. The particular situation of New Jersey citizenry is to a large extent defined by these

larger social and economic patterns. These larger social and economic conditions, in turn, affect the predicament of the elderly. Thus, in order to understand the workings of policies within New Jersey toward the elderly, it is necessary to examine the larger national patterns which encompass and affect the Garden State.

We shall proceed in this chapter by laying out the demographic patterns of the elderly. This will include both a national composite of the elderly's situation and a demographic profile of New Jersey's elderly population. In examining the outstanding problems and needs of New Jersey's seniors, we shall make some comparisons between the State's elderly and nonelderly citizens. In Chapter II, we shall examine the Federal Government's role in meeting the needs of the elderly. Chapter III will focus on the New Jersey Government role in serving the senior citizen population.

Chapter IV will focus on the central institution at the county level handling responsibilities for elderly matters—the County Offices on Aging. Much of the discussion in this chapter will center on the functions performed by the County Offices on Aging. Chapter V will examine other county government roles as well as the roles of New Jersey municipalities and housing authorities in providing for the elderly. Given the paucity of data and wide variation in roles, at least for the municipalities, our discussion here will provide a general grasp of services rendered for the elderly rather than constituting a comprehensive, rigorous detailing of all the services furnished by New Jersey municipalities. The final section, Chapter VI, will conclude with the recommendations of our Commission.

NATIONAL GROWTH OF THE ELDERLY POPULATION[1]

In the early years of the Republic, given the brevity in life longevity, the age gap between the older segment of the population and the rest of the citizenry was not pronounced. In contrast, one of the most significant demographic trends of current America is the extension in the age differentials of its population. Since 1900, average life expectancy has increased by 26 years, with the last two decades experiencing a growth of the older population at a rate twice as fast as that of the rest of the country's populace.

The Aging Of The American Population

Whereas, as recently as 1900, one in 25 Americans was age 65 and over, by 1984, the proportion had winnowed to where one in eight (12%) was at least 65 years of age (Table I-1 and 2). U. S. Census Bureau estimates for 1984 projected 28 million Americans age 65 and older, with over 22 million Americans between the ages of 55 and 65, awaiting incorporation into the elderly population (Table I-2). In fact, demographers have projected that in the mid-part of the 21st Century, more than one in five Americans (over 67 million citizens) will be elderly (Table I-1).

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[1]Much of the data reported in this section were obtained from *Aging America: Trends and Projections 1985-86 Edition* (U.S. Congress) and *Developments in Aging: 1985 Volume 3—America In Transition: An Aging Society* (U.S. Congress: 1986).

TABLE I-1

ACTUAL AND PROJECTED GROWTH OF THE OLDER POPULATION, 1900-2050
(Numbers in thousands)

Year	Total population all ages	55 to 64 Years		65 to 74 Years		75 to 84 Years		85 Years and Over		65 Years and Over	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
1900	76,303	4,009	5.3	2,189	2.9	772	1.0	123	0.2	3,084	4.0
1930	122,775	8,397	6.8	4,721	3.8	1,641	1.3	272	0.2	6,634	5.4
1960	179,323	15,572	8.7	10,997	6.1	4,633	2.6	929	0.5	16,560	9.2
1980	226,505	21,700	9.6	15,578	6.9	7,727	3.4	2,240	1.0	25,544	11.3
1990	249,657	21,051	8.4	18,035	7.2	10,349	4.1	3,313	1.3	31,697	12.7
2000	267,955	23,767	8.9	17,677	6.6	12,318	4.6	4,926	1.8	34,921	13.0
2020	296,597	40,298	13.6	29,855	10.1	14,486	4.9	7,081	2.4	51,422	17.3
2050	309,488	37,327	12.1	30,114	9.7	21,263	6.9	16,034	5.2	67,411	21.8

SOURCES: 1900-80 U.S. Bureau of the Census, *Decennial Censuses of Population, 1990-2050;* U.S. Bureau of the Census, *Projections of the Population of the United States, by Age, Sex, and Race: 1983 to 2080, Current Population Reports, Series P-25,* No. 952, May 1984.

Furthermore, the life span of the elderly population is further being extended largely as a result of improved economic conditions and advances in medical technology. Thus, the aging trend is expected to continue. While presently around 40 percent of senior citizens are 75 years of age and older, by the year 2000, approximately half of the elderly population is expected to be at least 75 years of age (Graph I-1). Experiencing particularly rapid growth is the oldest segment of the elderly population, those 85 years of age and over. This age group is expected to triple in numbers between 1980 and 2020 (Table I-1). The growing numbers of older elderly has broad ramifications for public policy because of this age group's intensified need for health and social services.

One of the most striking phenomenon is the increase in the ratio of elderly to persons of working age (ages 18 to 64). In 1900, four percent of the population was age 65 and over, with a ratio of seven elderly persons for every 100 persons of working age. By 1984, the elderly's share of the population had risen to over 12 percent, with almost 19 elderly persons per 100 of working age. By 2020, the ratio is projected to rise to about 29 elderly per 100 working age citizenry, and a ratio of 38 elderly per 100 working age persons by the year 2050.

With people living longer and having fewer children, the "elderly support ratio" portends potentially serious difficulties that need to be addressed. The support ratio is economically significant since it is the labor force population that financially underwrites the government's social programs aiding the nonworking population. A higher ratio of elderly to working population thus places a greater strain on those working to provide the tax funding to maintain a given level of benefits for retirees.

Labor force participation decreases precipitously with age. Thus for 1984, while approximately 90 percent of men and 60 percent of women, age 50 to 54, were working, by age 60 the figures had declined to around 68 percent of men and 40 percent of women. Furthermore, for the elderly desiring work, unemployment cycles and job discrimination pose great difficulties. Surveys have shown that three-quarters of the American labor force desires to continue in a part-time capacity after retirement.

Income And The Elderly

Greater variation exists in the economic circumstances of the elderly than of any other age group. U.S. 1980 Census data showed that while over 20 percent of the elderly have annual incomes above $20,000, 15 percent of the elderly were below the poverty line of $5,475. Another 10 percent of the elderly population were living close to the poverty line of $5,475-$8,000. Seniors live under conditions of great financial vulnerability. The possibility of a decline in income resulting from retirement, the loss of a spouse, the occurrence of health problems, or the ravages of inflation, each of these can place the elderly in a precarious situation. As the elderly earn substantially less income than the under 65 population, i.e. the 1984 median income for family households headed by an elderly person was $18,236 compared to that

TABLE I-2

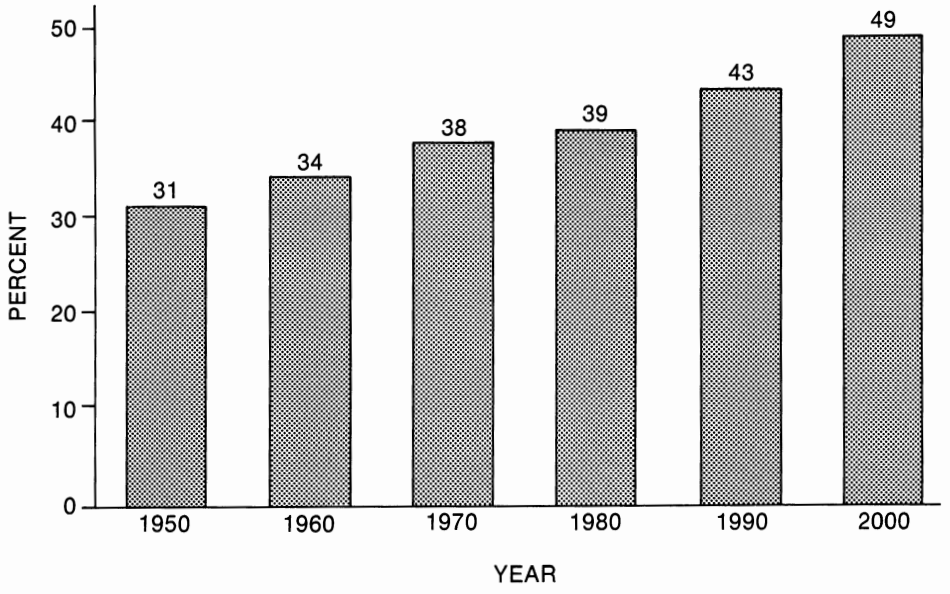
DISTRIBUTION OF THE POPULATION BY OLDER AGE GROUPS, 1984

Age Group	Number	Percent
All ages	236,416,000	100
0 to 54	186,220,000	79
55 to 64	22,210,000	9
65 to 74	16,596,000	7
75 to 84	8,793,000	4
85 plus	2,596,000	1
55 plus	50,195,000	21
65 plus	**27,985,000**	**12**

SOURCE: U.S. Bureau of the Census, *Current Population Reports,* Series P-25, No. 952, May 1984.

GRAPH I-1

PERCENTAGE OF ELDERLY PERSONS WHO ARE AGE 75 AND OVER: 1950 to 2000



In 1989, the young old (age 65 to 74) outnumbered the oldest old (age 75 or older) by three to two. By the turn of the century, half of the elderly population are expected to be age 65 to 74 and half will be age 75 or older.

Source: U.S. Bureau of the Census, *Current Population Reports,* Series P-25, No. 952, May 1984, and Decennial Censuses of the Population, 1950-1980.

of $29,292 for families with heads age 25-64 (62 percent of that of nonelderly family income); with elderly individuals receiving only 47 percent of that of nonelderly individuals, $7,349 to $15,561, larger numbers of them live on the economic edge (Graph I-2).

While the proportion of elderly living in poverty is slightly below that for the nonelderly, higher percentages of the elderly are found close to the poverty line (Table I-3). Poverty rates for the elderly increase as one moves toward the older subgroups. For example, the 1983 poverty rate for the age 85 and over population was 21.3 percent, nearly twice that of the 65 to 74 age bracket (11.9 percent). Also, median income for an elderly headed family, age 85 and older, is only two-thirds of a family headed by an elderly person age 65 to 74. For the unattached elderly, those 85 and older have a median income three-quarters of that of seniors between the ages of 65 and 74.

Women, in particular, given their past subordinate economic condition, much more adversely experience diminution in income. In 1984, the median income of elderly women ($6,020) was only slightly over half that of elderly men ($10,450). In large part this is attributable to past patterns of lifelong economic dependency on men. As the primary breadwinners, men provided the lion's share of pension and Social Security monies. With women living longer than men, there tends to be a substantial loss in income when they become widowed, as they lose full entitlement to their spouse's pension and Social Security benefits. Thus, one of the conditions in need of attention is the impoverishment of women among the present generation of senior citizens.

TABLE I-3

PERCENT OF ELDERLY AND NONELDERLY PERSONS BY RATIO OF INCOME TO POVERTY, 1984

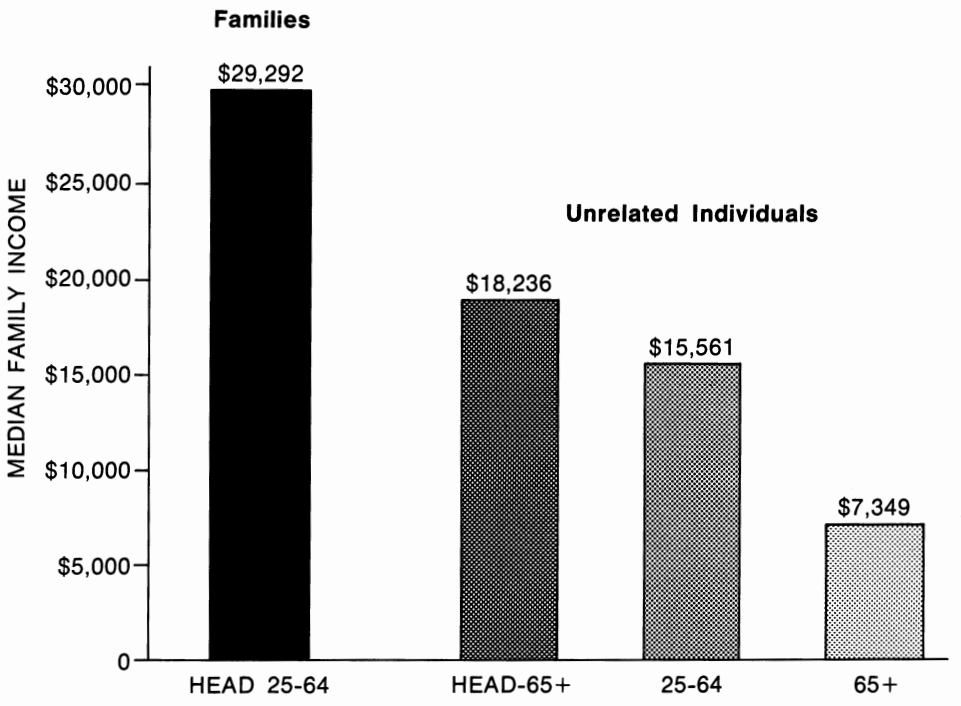
	Age	
Ratio of Income to Poverty Level	**Under 65**	**65 and older**
Below poverty	14.7	12.4
100 to 124 percent poverty	4.5	8.8
125 to 150 percent poverty	5.1	7.9
Total below 150 percent	24.3	29.1

SOURCE: Special tabulation of *March 1985 Current Population Survey,* U.S. Bureau of the Census.

With the general rise in Social Security and private pension benefits over the past 20 years, the current population of elderly are better off than previous generations of elderly. Whereas, one-third of the elderly lived in poverty in 1960—roughly double the rate of that of nonelderly adults—the 1984 poverty rate had declined to 12.4 percent. Between 1968 and 1984, elderly families' share of income realized from earnings declined from 48.2 to 28.6 percent,

GRAPH I-2

MEDIAN INCOME—ELDERLY AND NONELDERLY 1984



Source: Unpublished data provided by the U.S. Bureau of the Census, September 1985.

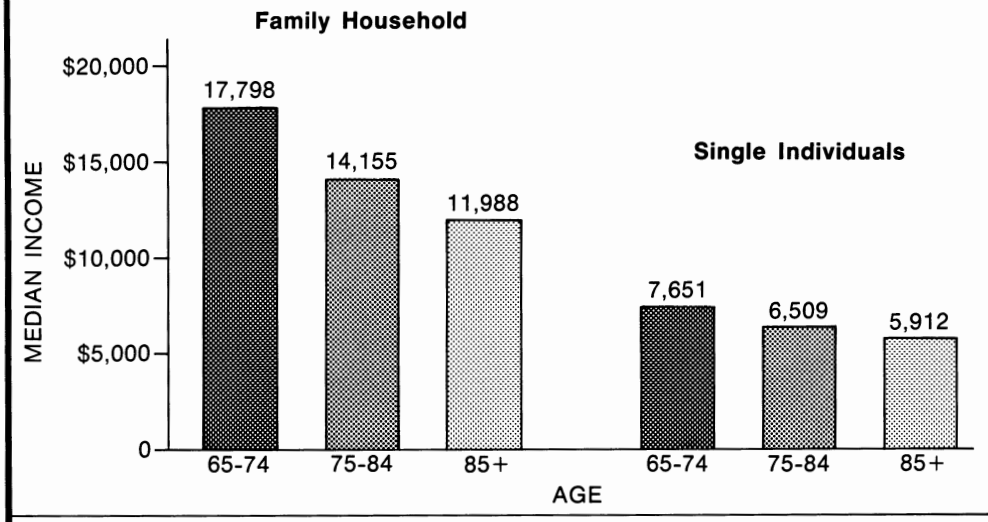
while Social Security benefits' proportion of income increased from 22.9 to 31.6 percent and that of asset income from 14.6 to 23.7 percent. For 1982, 40 percent of all income received by elderly households came from Social Security and 25 percent from assets income (Graph I-4). Thus, the dependency of the elderly on earnings has diminished sharply as the support provided by Social Security benefits and assets income has risen in importance.

AREAS OF CRITICAL NEED

The two most critical areas affecting the quality of life for senior citizens are ***maintaining independent residence*** and ***proper health care.*** Inability to cope in meeting either of these needs produces serious diminishment in life's meaningfulness. Amelioration of problems in both areas is heavily dependent upon one's financial resources, and difficulties can, in turn, rapidly deplete the capital elderly persons have accumulated over the course of their lives.

GRAPH I-3

MEDIAN ELDERLY INCOME—FAMILIES AND INDIVIDUALS BY AGE 1983



Source: U.S. Bureau of the Census, *Current Population Survey,* March 1984.

Health Care And The Elderly

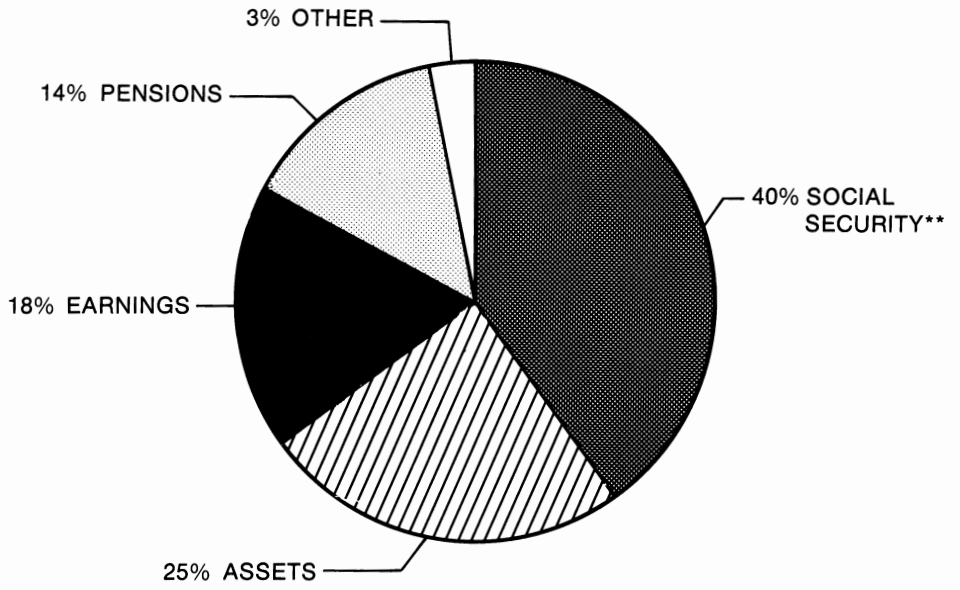
Given the decline in health with age, the need of the elderly for health care and related services becomes greater with advancing years. Figures indicate that 43 percent of elderly men and 35 percent of elderly women suffer a chronic condition that limits them in performing a major personal activity.[2] Senior citizens thus require much greater health services than the nonelderly population. The frequency of hospitalization is twice that of the rest of the population, their stay twice as long, and their use of prescription drugs double that of the nonelderly. Though only five percent of the elderly reside in a nursing home, this still amounted to a 1985 national total of 1.5 million elderly nursing home residents.

Though ***making up only 12 percent of the nation's population, the elderly account for 30 percent of all hospital discharges and a third of the nation's total personal health care expenditures.*** Estimates, for 1984, of the elderly's individual health care expenditures is $4,202 per person; this comes to ***a national total for personal health care expenditures for the elderly of approximately $120 billion.***

[2]National Center for Health Statistics, Vital and Health Statistics Series 10, Nos. 96, 126, 130 (1978).

GRAPH I-4

INCOME SOURCES AGED UNITS 65 AND OLDER* 1982



*An aged unit is either a married couple living together with one or both members 65 or older, or an individual 65 or older who does not live with a spouse.

**Includes Social Security and Railroad retirement which account for about one percent of income for aged units.

Source: *Income of the Population 55 and Over,* U.S. Department of Health and Human Services, Social Security Administration, 1982.

Although public expenditures for elderly health care is considerable, the elderly nevertheless bear a substantial, personal, financial burden for their health care expenses. Few people realize that Medicare pays for less than 50 percent of the elderly's health costs, with personal out-of-pocket payments for health care expenditures accounting for 25 percent of the total amount (Graph I-7). As Graph I-8 shows ***the two major categories of elderly out-of-pocket health expenses are nursing homes and physicians, comprising 42 and 21 percent of total out-of-pocket health care expenditures respectively. Present senior citizens' direct out-of-pocket health expenses average 15 percent of their income, the same proportion as before the passage of Medicare and Medicaid.*** The U.S. Health Care Financing Administration estimates that ***the elderly's out-of-pocket health care expenses averaged over $1,000 per person in 1984.*** Medicaid expenditures, of which the states cover roughly half of the costs, encompass roughly 13 percent of the elderly's

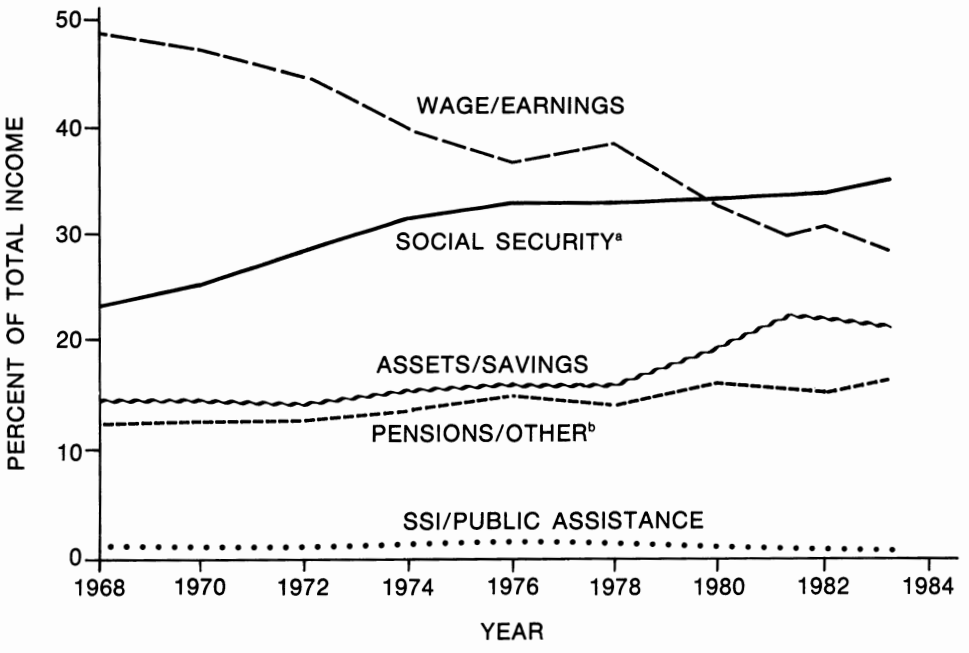
personal health care expenditures, with the overwhelming share of the funding provided for senior citizens requiring long-term care (See Table I-4 for present expenditure patterns regarding long-term care).

Catastrophic illness, one of the most serious health cost problems of the elderly, is being addressed currently by national legislation. Action on catastrophic illness by the Federal Government will provide protection for 31 million Medicare recipients—28 million elderly and three million disabled persons, and leave long-term care coverage as the remaining, outstanding health-care need of the elderly. Under the current legislation, Medicare beneficiaries would pay a deductible under $1,500 before receiving full coverage for doctor care and a deductible of about $500 for hospital care. Also being realized is coverage of prescription drug costs beyond a $600 deductible.

Specifically, the passage of catastrophic illness coverage is expected to: 1) increase Medicare coverage of skilled nursing facility stay for up to 150 days

GRAPH I-5

INCOME SHARES BY SOURCE OF INCOME
FAMILIES WITH HEAD AGE 65+
1968-1983



[a]Includes Social Security and railroad retirement.
[b]Includes veterans' payments, unemployment, workers compensation, annuities and alimony.

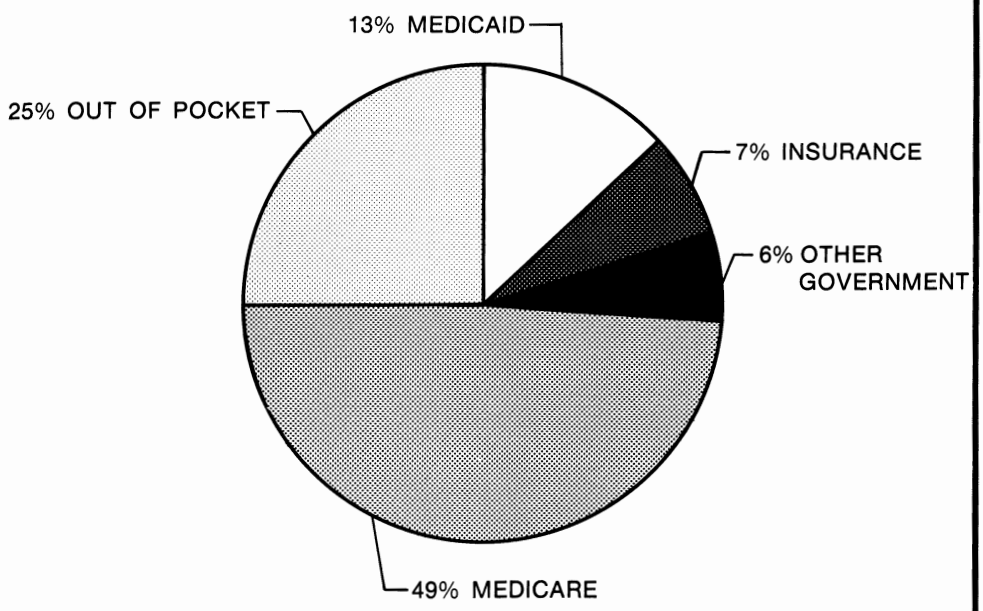
Source: Bureau of the Census, *Current Population Surveys, 1969-83,* Unpublished data.

of care 2) expand Medicare coverage for hospice care[3] beyond the current 210-day limit 3) provide Medicare coverage beyond current limits on extensive home-care visits. Funding for the legislation will be based on an increase in the Medicare premium charge, with each individual on Medicare having their basic premium charge increased and having a higher premium to pay for prescription drugs, with the premium determined by a person's income.

With projected population increases of the elderly in total numbers and in their percentage of the nation's population, the elderly will continue to consume larger shares of the nation's health care expenditures. Given the continued spiral of health care costs, the mounting levels of expenditures and expanded programmatic content of services necessitate closer analysis in order to maximize benefits for the recipients and ensure greater efficiency in the use of the nation's resources for elderly health care.

GRAPH I-6

PERSONAL HEALTH CARE EXPENDITURE FOR THE ELDERLY BY SOURCE OF PAYMENT: 1984

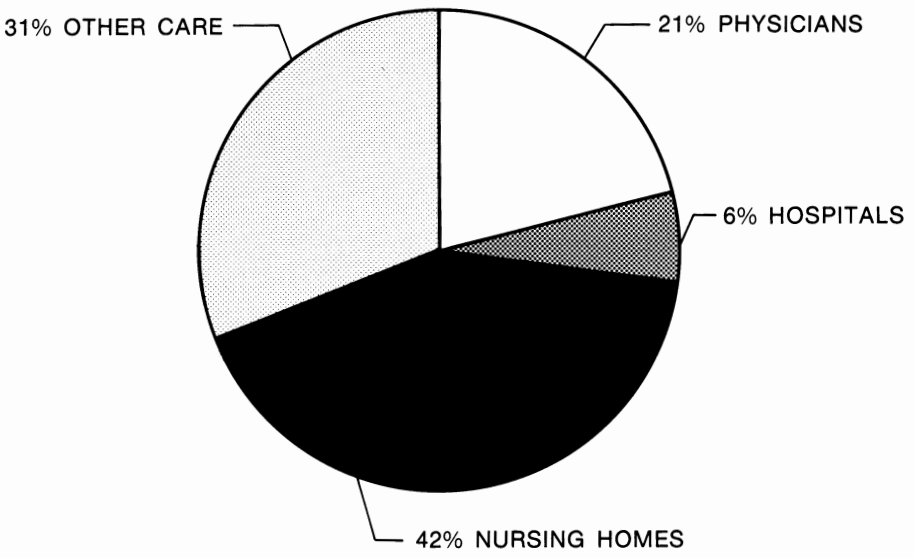


Source: Health Care Financing Administration, Office of Financial And Actuarial Analysis.

[3]Hospice care is an approach to caring for the terminally-ill that focuses on comfort and social support during the last phase of life. The emphasis is on personal care rather than technologically based medical treatment.

GRAPH I-7

WHERE THE OUT-OF-POCKET DOLLAR FOR THE ELDERLY GOES: 1984



Source: Health Care Financing Administration, Office of Financial and Actuarial Analysis.

Residence Patterns Of The Elderly

Contrary to popular conceptions, the elderly, upon retirement, generally remain in their communities of residence rather than migrate geographically. The geographic stability of the elderly, which is a by-product of both financial constraints and a desire to retain close ties with friends and family, has produced a graying of particular geographical areas. States with well settled populations, or ones from which the young have emigrated because of poor economic opportunities, have higher percentages of the elderly. In contrast, some of the sunbelt states, such as Arizona, Florida, Nevada, as recipients of retiring elderly, have experienced tremendous growth resulting from an in-migration. Given the desire and tendency for people to age in place, legislators and policy makers would be wise to advance policies that take this factor into account.

Of particular saliency is the growth of the elderly suburban population, itself, in part, attributable to the opening of suburban areas some 40 years earlier. A sampling study done in 1980 revealed an elderly suburban population just under 12 percent, with over 10 million seniors residing in the suburbs. This finding reveals that suburban areas have replaced central cities as reservoirs of elderly populations.

TABLE I-4

Long-Term Care Expenditures* For Recipients Age 65 And Over**

Sample States	1975	1984	Percentage Change 1975 to 1984
Total For All States	**$3,620,921,772**	**$9,029,083,617**	**149.4**
California	$ 270,763,258	$ 587,492,129	116.9
Connecticut	67,125,572	215,418,473	220.9
Florida	59,259,685	241,040,520	306.8
Illinois	134,788,483	293,191,566	117.5
Massachusetts	162,271,532	286,987,252	76.9
Michigan	160,084,929	315,248,440	96.9
New Jersey	**103,324,978**	**287,300,850**	**178.1**
New York	897,306,751	1,793,901,998	99.9
Ohio	146,441,272	405,998,617	177.2
Pennsylvania	278,208,082	520,046,214	86.9
Texas	209,880,724	400,123,322	90.6

*Expenditures include total Federal-state spending for skilled nursing facilities, intermediate care facilities, and intermediate care facilities for the mentally retarded.

**Data supplied by the Health Care Financing Administration, U.S. Department of Health and Human Services.

While for many senior citizens their home is their most important capital asset, nevertheless, sharp disparities exist among the elderly. Of the 17.7 million elderly households in 1983, 75 percent occupied owner-owned homes and 25 percent lived in rental dwellings. Of the owner-occupied houses, the 1980 Census reported that 80 percent of these were owned free and clear. ***Compared to the nonelderly population, higher percentages of the elderly are home owners.***

However, while good percentages of senior citizens have achieved a comfortable housing situation, for substantial numbers of others the costs of residence constitute a significant burden. Whereas elderly males, ages 65-69, whether renters or mortgage payers, have housing costs somewhat above 20 percent of their income, for home owners, who have fully paid off their mortgage, the figure is only 11 percent.

As the elderly age, their percentage of income devoted to housing costs increase. Given that the elderly are more likely to live in older homes, the financial costs for maintenance are likely to be greater. Disproportionate numbers of elderly live in inadequate housing. For the elderly renters, about 15 percent (696,000) of the males in 1980, and about seven percent of the females (1,155,000), had no phones.

NEW JERSEY ELDERLY POPULATION PROFILE

As is true nationally, New Jersey's elderly constitute a highly heterogeneous population with great diversity in income, housing, and health status. Despite dissimilarity in many respects, they share in common a life-situation based on the vicissitudes of old age. These include a decline in income stemming from work force retirement, a need for increased medical attention, and increased likelihood of dependence on other persons and institutions for support in the later years of the life cycle.

The current focus on New Jersey's elderly population is understandable since senior citizens form the fastest growing segment of the State's population—a pattern consistent with the national trend in which the numbers of elderly continue to increase at a rate greater than the population as a whole. ***A comparison of 1970 and 1983 figures reveals that New Jersey's elderly population increased by 32 percent, while the numbers of nonelderly increased by only one percent.*** Of the State's estimated 1986 population of 7.62 million residents, over 980,000 fall within the 65 and over age category—about 13 percent, or one in eight, of the State's total population.[4] Thus, projections for the current year indicate ***a present senior citizen population for New Jersey of over one million.***

Data on retirement migration patterns show that, between 1975 and 1980, 87,000 elderly emigrated from the state of New Jersey. This makes New Jersey fifth in the country among the states in out-migration, with New York (243,000), California (141,000), Illinois (120,000), and Florida (92,000) surpassing New Jersey in this regard. New Jersey is similarly fifth in the country in elderly immigration, with over 50,000 senior citizens immigrating into the State between 1975 and 1980. Only Florida, California, Arizona, and Texas had larger senior citizen immigrations.[5]

New Jersey has the second highest median age in the country, following only Florida, ranks ninth in total elderly population, and is one of nine states which collectively contain over 52 percent of the nation's elderly population. Within the elderly population, those 75 of age and over constitute a rapidly growing subgroup. While presently comprising 40 percent of the State's elderly, by the year 2000 the 75-plus group will constitute close to 50 percent of the elderly, an increase of 79 percent when compared with their 1980 standing within the elderly population.

Particularly striking is the increase in the 85-plus age groups, that section of New Jersey's elderly population most in need of societal services. This age group, which in 1980 comprised 8.4 percent of the elderly, is projected to increase by about 124 percent by the year 2000. These changing demographics of New Jersey's elderly population reveal a heightened need for State and county planning to anticipate future service levels and expected forthcoming problems.

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[4]*Population Estimates for New Jersey July 1, 1986* (Trenton, State of New Jersey, Department of Labor: September 1987), p.37.

[5]The Retirement Migration Project, Center for Social Research in Aging, University of Miami, Sept. 1984.

TABLE I-5

NEW JERSEY POPULATION PROJECTIONS FOR SENIORS

YEAR 1980			Projections for Year 2000		
Age 75+	329,064	38%	75+	588,460	49%
Age 85+	72,231	8.4%	85+	161,460	13.5%
Total Elderly	859,771		Total Elderly	1,205,210	

Change From 1980 to 2000

Age 75+	79% Increase
Age 85+	124% Increase

Source: *Population Estimates for New Jersey July 1, 1986.*

Feminization of Poor Elderly

Another area in need of attention is the increasing feminization of New Jersey's elderly population. This is so because women as a group outlive males. At present, women account for 60 percent of New Jersey's elderly; by the year 2000, projections for the State of New Jersey are that there will be about 751,000 elderly females to about 454,000 males.[6]

The differential in the life span between the sexes presents problems in need of address. Three factors conjoin to produce a markedly worse life situation for New Jersey elderly women: the disparity in income between males and females, the greater numbers of elderly females living unattached, and the enlarged housing expense burden of elderly women. ***While approximately 71 percent of New Jersey's elderly male population are married and live with their wives, the majority, 53 percent, of elderly women are widowed.*** Of New Jersey's 547,000 households headed by an elderly person, or having a 65-plus age spouse, 40 percent of these households are made up of an elderly person living alone. By far the largest percentage of these are elderly women, with one out of three (35.4 percent) elderly women in New Jersey living alone, compared with one in seven (13.6 percent) males.[7]

This sex differential takes on added significance when the current income gap between elderly men and women in New Jersey is examined. Figures for 1984 reveal that the median income, within the State, for those working was approximately $27,500 for men and $12,000 for women. For the New Jersey elderly population, men's median income had dropped to about $12,000, while that of elderly women had dropped to approximately $6,000.

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[6]*Population Projections for New Jersey and Counties: 1990 to 2020, Vol. 1* (Trenton, State of New Jersey, Department of Labor, November 1985), Table 5, pp.13 and 16.

[7]Figures provided on sex differentials in age span are for 1980.

This marked decline in income as one moves from the working population to the elderly population, while less precipitous for women than men, nevertheless, because women start so much lower, leaves many women on the edge of poverty. With the elderly male presently constituting the major contributor to household income—through greater pensions, Social Security benefits, and employment earnings—his death often leaves the surviving spouse at an income level in or near poverty. Of New Jersey's 1983 elderly poverty rate of one-in-ten of the State's senior citizens (about 91,000 people), the vast majority were women. For New Jersey, twice as many elderly women (12.4%) as elderly men (6.2%) are poor. It should also be noted that the elderly poverty rate is somewhat above New Jersey's overall poverty rate of 9.5 percent for all citizens. This compares with national statistics of one out of eight elderly Americans living in poverty.

What sharply differentiates the income levels of the elderly from the nonelderly are their percentages of "near-poor," i.e., those living within 125 percent of the poverty threshold. New Jersey 1979 figures revealed that 13 percent of elderly households were within the "near poor" category. While these figures are encouraging compared to the national figures of 21 percent of the nation's elderly being "near-poor," they are significantly above that of the rest of the State's population.

Elderly Housing Situation

Also, closely interwoven with incidence of poverty is the housing situation of the elderly. Two factors stand out in defining the interconnection between housing and poverty: whether the elderly are part of a family household or live alone, and their renter-ownership status. ***For New Jersey's elderly, the incidence of poverty is much higher among persons living outside a family household. Thus, about 24 percent, or 53,000 of New Jersey's senior citizens living alone are in poverty, compared with only four percent for the elderly living within a family household.***

Though no recent figures are available for New Jersey, national data for 1980 reveal that about two-thirds of elderly renters lived alone while only about 37 percent of elderly homeowners did so. With the extension of the life span, the trend has been toward greater percentages of elderly living independently—a pattern that, as a rule, entails higher levels of government services. The factor of solitary home life is one of the best predictors of poverty for the elderly, with 63 percent of single elderly homeowners living in poverty and 79 percent of single elderly renters in poverty.

Though high percentages of the elderly owned their own homes outright—in New Jersey, for example, in 1980, 64 percent of elderly households owned their own homes—serious income difficulties for many of these elderly remain. Possession of one's home, while reducing housing costs, does not generate additionally needed income. Thus, a 1983 U.S. Census Bureau of Housing survey found that 60 percent of elderly, poverty-stricken households were made up of homeowners.

TABLE I-6

FAMILIES AND NONFAMILY HOUSEHOLDERS BY POVERTY STATUS IN 1979, BY AGE OF HOUSEHOLDER FOR NEW JERSEY

	FAMILIES	NONFAMILY HOUSE-HOLDERS
INCOME BELOW POVERTY LEVEL:		
15 TO 64 YEARS	133,847	54,265
65 YEARS AND OVER	14,117	50,172
INCOME BETWEEN 100 AND 124 PERCENT OF POVERTY LEVEL:		
15 to 64 YEARS	40,551	13,070
65 YEARS AND OVER	10,595	37,240
INCOME 125 PERCENT OF POVERTY LEVEL AND ABOVE:		
15 TO 64 YEARS	1,473,249	315,552
65 YEARS AND OVER	269,749	137,883

Source: *U.S. Census 1980.*

The roots of the problem lie in the elderly's diminution of household income with retirement and a spouse's death. Meeting housing costs becomes harder, therefore, if only one person rather than the couple's income is available. With the loss of a spouse, the remaining partner—which is more likely to be a woman—is apt to find the strain of housing costs to be severe.

This may seem surprising, given the high percentage of elderly owning their own homes. Given that many of the elderly live in the oldest housing stock, the communities where they settled some 30 to 40 years ago, maintenance and repair costs in such locations are considerally above that incurred by the rest of the homeowning population. National figures indicate that maintenance and repair costs for the elderly completely owning their homes comprised 16 percent of their income compared to 10 percent for the nonelderly. With most of the elderly at much lower income levels than the younger households, their budget is a much tighter one. Thus further increases in housing expenses or diminution in income may spell financial disaster.

A Bureau of Census 1985 survey of New Jersey elderly homeowners found that about 45 percent were without a spouse and that income diminished sharply with passing age. For example, for a New Jersey near-elderly (age 60-64), married couple median income was $44,000; at age group 75 to 79, median income had dropped to about $19,500, with a further drop to under $14,000 in the age bracket 80 to 84. Single elderly, male homeowners' income, while closely paralleling that of elderly married couples up to age 75, then

precipitously declines in relation to it thereafter. For single, female elderly homeowners' income, it constitutes less than half of their male counterpart's income up to age 75, after which the two income levels become comparable. As illustration of the greater difference: median income for a single male householder, age 70-74 approached $23,000, while for the female, median income was under $10,000.[8]

For New Jersey, 13 percent of elderly-headed households are living in poverty. National figures indicate that 41 percent of the elderly living in poverty spent at least 45 percent of their income on housing. In 1980, ***New Jersey elderly renters used 33 percent of their income for housing, compared with 23 percent for nonelderly renters.*** Nationally, an elderly woman, living alone, had as median rent 50 percent of her income.

The above noted patterns suggest ***a nexus of life situations based on the gender of the elderly person—whether they are part of a family household or living unattached, renting or owning their unit of residence—which collectively are likely to produce an individual requiring supportive services to maintain a life without serious deprivation. A profile of such elderly finds them likely to be living alone, renters, of limited income, elderly women, and socially isolated.*** With reductions in Federal and State funding for housing programs the past few years, there is a need to re-examine the roles that county, municipal, and State Government can play in alleviating these growing problems.

Besides male-female and single-couple differentials in income, there exist significant racial differentials as well. Of those elderly depending on their monthly Social Security checks for at least 90 percent of their income, 40 percent of elderly blacks (compared with only 20 percent of the overall elderly population) were in this predicament. Figures for 1985 reveal that Social Security benefits averaged $490 per month.

Regarding Supplementary Security Income (SSI) for the elderly poor, while only five percent of the white elderly were on Supplemental Security Income, ***one out of four elderly Hispanics and more than one out of five elderly blacks were Supplemental Security Income recipients.*** Furthermore, for 1980, while Supplemental Security Income and Public Assistance provided two percent of the income for all elderly households, it constituted 10 percent of total income for black households.

The poor elderly are thus disproportionately made up of elderly females, those over 75, Hispanics and blacks, and singles. Statistics for 1979 showed ***25 percent of New Jersey's elderly blacks and Hispanics lived in poverty, compared to less than nine percent of elderly whites.*** Over 40 percent of the nation's elderly black women were poverty-stricken for 1983, and over half, 54 percent, were either poor or near-poor. The poorest subgroup among the elderly were black women living alone or with nonrelatives, with more than three-fourths living in or near poverty in 1983.

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[8]"Owner Occupied Units, Household Type and Income In 1985 In New Jersey," *Current Population Survey*, Bureau of the Census, March 1986.

Also part of the poverty equation is level of education and employment patterns. ***Currently, less than half of New Jersey's age cohort of 65 to 69 are high school graduates.*** This situation is expected to change for the next generation of elderly who have higher levels of education. Regarding work force participation, about 10 percent (94,000) of New Jersey's 1983 elderly population held full or part-time jobs. This compares with 18 percent of the elderly being employed in 1970. Of the total, 15 percent of elderly males and seven percent of the women had employment in 1983.

COUNTY ELDERLY DEMOGRAPHICS

There is great disparity in the distribution of New Jersey's elderly population among the 21 counties. Much of the elderly population is clustered in the counties contiguous to the great urban centers of New York City and Philadelphia. Figures for 1983 reveal that ***56 percent (519,000) of the State's elderly are located in the eight counties outerlying Philadelphia and New York City.***[9]

Since 1970, the 21 counties of New Jersey have witnessed increases in the number of elderly well above overall county growth rates. Atlantic County is the exception to this trend, with the elderly subset of its total population decreasing as both a proportion of the County's overall population and in absolute numbers (elderly population decline has numbered 400 over the last three years).

While the 65-plus age group has been increasing at a rate substantially greater than that of overall State population growth, as noted earlier, the State had a net outmigration of the elderly from 1975 to 1980. The shore counties, in particular, have been the focal point of the in-migration, with the counties of Ocean, Monmouth, and Cape May witnessing substantial in-migrations of elderly. The result is that the ***seashore counties have the 21 counties' highest percentages of elderly within their overall population,*** with Ocean County having 22.4 percent elderly of its total population, Cape May 20.2 percent, and Atlantic County 15.4 percent (down from 15.9 percent in 1980).

In seven of New Jersey's 21 counties, more than half of the population increase is attributable to the growth in elderly population.[10] For example in the counties of highest percentage increases in elderly population, the three highest for 1980-83, i.e. Middlesex, Burlington, and Ocean had increases of 15.5, 13.7, 13.4 percent respectively, with three more New Jersey counties having more than 10 percent increases from 1980 to 1983. The demographics of elderly increases in county populations are further revealed by the growth in elderly populations in Bergen and Passaic Counties, despite the decline in overall population in these two counties from 1970 to 1983.

Of importance for New Jersey, as is the case for the rest of the United States, is the growing number of elderly of advanced years. ***About two-fifths***

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[9]The counties outerlying New York City are Bergen, Essex, Hudson, Middlesex, and Union. For Philadelphia, the adjacent counties are Burlington, Camden and Gloucester Counties.

[10]The counties are Camden, Mercer, Middlesex, Morris, Ocean, Salem, and Somerset counties.

TABLE I-7

COUNTY DISTRIBUTION OF ELDERLY* IN POVERTY

COUNTY	Total Population	Persons 55+	Persons 55+ With Income Less Than 125% Poverty Level	Pct. Of State 55+ With Income Less Than 125% Of Poverty Level
New Jersey (state totals)	**7,364,823**	**1,622,005**	**207,877**	**100.00**
Atlantic	194,119	50,288	8,681	4.17
Bergen	845,385	209,822	17,187	8.19
Burlington	362,542	58,583	5,801	2.88
Camden	471,650	98,310	14,130	6.75
Cape May	82,266	27,012	3,783	1.85
Cumberland	132,866	27,663	4,847	2.38
Essex	851,116	185,792	33,039	15.84
Gloucester	199,917	35,753	4,930	2.36
Hudson	556,972	131,028	25,749	12.30
Hunterdon	87,361	15,279	1,463	0.71
Mercer	307,863	68,042	9,033	4.48
Middlesex	595,893	114,315	11,316	5.53
Monmouth	503,173	105,419	13,033	6.28
Morris	407,630	70,997	4,883	2.35
Ocean	346,038	108,411	12,432	5.93
Passaic	447,585	98,335	14,026	6.73
Salem	64,676	14,130	2,419	1.16
Somerset	203,129	37,490	3,305	1.60
Sussex	116,119	18,161	2,234	1.07
Union	504,094	128,462	13,362	6.37
Warren	84,429	18,713	2,224	1.07

Source: Lawrence Berkeley Laboratory, Data for December 1985.

*Elderly is here defined as those over age 55.

of New Jersey's elderly are over 75 years of age. Given the significantly higher levels of services needed by this age group, those counties and municipalities experiencing the sharpest growth rates in the advanced elderly population will find themselves pressed to play an increased role in the provision of supportive services. The latest figures indicate that Atlantic (with 31%), Monmouth (29%), Sussex (28%), and Morris (28%) Counties have the highest percentages of the elderly in the 75-plus age bracket.

One of the most striking phenomenon of elderly demographic patterns is the aging of New Jersey suburbia, particularly the more established bedroom communities. With the general residential pattern being one of remaining in one's community from middle age to the retirement years, those suburbs established in the post World War II period by newlyweds are now beginning to experience increasing numbers of elderly residents. Over the next couple of decades, these growing elderly population concentrations will play a key role in defining the economic and social direction of their suburban communities.

Another emerging residential phenomenon of the elderly in New Jersey is the growth in adult retirement communities. Their proliferation has been particularly marked in shoreline counties. A strong concentration exists in Ocean County which contains 30 out of the State's 41 retirement communities. With present growth occurring in shoreline and selected rural counties, the changing elderly demographics, in of itself, are likely to impose future requirements of additional health and social services.

The elderly demographics of poverty and income among the different counties affect the capabilities of various counties to address these needs. New Jersey had traditionally been one of the leaders among the states in per capita income. Figures for 1983, for example, show that per capita income in New Jersey was $1,683 greater than the national average. Great income disparities exist, however, among New Jersey's counties. The three counties of Somerset, Morris, and Bergen had per capita incomes over $4,500 above the national average, while four of New Jersey's 21 counties—Cumberland ($8,031), Hudson ($8,543), Salem ($9,029), and Gloucester ($9,411)—were below the national figure.[11] ***New Jersey's poor elderly are concentrated in the heavily urbanized counties adjacent to New York City: Essex (13.5 percent of the State's poor elderly), Hudson (15.7%), Bergen (6.3%), Passaic (10.2%) and Union (8.0%).*** With the exception of Bergen and Union Counties, these counties have poverty rates significantly above the State's average of 9.5 percent (for 1979).

Other counties, with insignificant elderly population concentrations, nevertheless have high percentages of their elderly in poverty: included are previously mentioned Hudson and Essex counties, and in addition we have the rural counties of Atlantic (13.6%), Cumberland (12.5%), and Salem (11.2%). Unfortunately, these are also the counties which have the higher poverty rates among the 21 counties and the ones that lag in per capita income.

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[11] *State and Local Expenditure and Revenue Policy Commission* "New Jersey Economy" (N.J. State Government: Trenton, 1987), p.48.

Cumberland, Salem, and Hudson Counties remain some $2,000 to $3,000 below the State average in per capita income, while Atlantic and Essex Counties are approximately $1,000 below the State average. The percentage of the county population living in poverty is also much higher in the above counties, with Essex and Hudson approaching twice the New Jersey poverty rate in 1979.[12]

Given the lower income levels and higher rates of poverty of the counties with higher percentages of poor elderly, their capacity to address the problems of the elderly is generally less than the other counties of New Jersey. This mismatch between funding capacity and elderly needs, though mitigated somewhat by intergovernmental transfers of monies from State and Federal sources, still leaves an imbalance between the geographical distribution of financial resources and elderly in need.

In addition, there are numbers of municipalities in New Jersey in which the elderly comprise 20 percent or more of the total population. The 1980 Census revealed 42 such communities. Most are located in the shore counties of Ocean and Cape May. The municipalities of Manchester Township, Cape May Point Borough, Longport Borough, Berkeley Township and Stone Harbor Borough have over a third of their population that is elderly.

SUMMARY

As we have seen, the State of New Jersey mirrors the nation in the growth of both the total numbers of senior citizens and their percentage of the overall population. The New Jersey elderly presently comprise one-in-eight of the State's residents, constituting over one million of New Jersey's population. As is true nationally, New Jersey's elderly constitute the fastest growning segment of the population. Among New Jersey's elderly, the 75-plus age group is the most rapidly increasing.

The demographic data also pinpoint several problem areas that are likely to become more pronounced as our population ages. For policy-makers, this demographic data should be construed as flash points, high-lighting societal problems that need to be addressed. Remedial action will be necessary based on the combined efforts of New Jersey State and local government.

The two substantive areas which will require policy-makers' attention are *health care* and *housing.* While the elderly are not a homogeneous group and those seniors in need of attention constitute a substratum of the elderly population, nevertheless, a confluence of traits serve to identify that portion of the ***elderly population most likely to be experiencing hardship: the frail elderly (high percentages of which are in their 80's), those living alone (particularly unattached elderly women), renters, and racial minorities.***

With increasing old age comes lower income and greater need of medical services. Given that women outlive men, higher percentages are likely to be living alone. Those living alone experience higher rates of poverty. Thus, several factors converge to produce an elderly subpopulation in need. The question of our time is how best to address those needs.

[12] *Ibid,* p.50.

CHAPTER II
FEDERAL POLICY TOWARD THE ELDERLY

INTRODUCTION

New Jersey local governments' program responsibilities toward the elderly generally are well integrated with State and Federal policy. Thus, to fully understand local functions on behalf of the elderly, we must be cognizant of how they connect to State and Federal policies. This chapter will examine the major Federal policies targeted at the elderly. We shall outline the main Federal programs servicing the elderly and the role performed by these programs in meeting the needs of New Jersey's senior citizens. In crucial areas for the elderly, the Federal Government sets the framework for State and county action through its programs and funding to New Jersey State and county governments. Beginning with the establishment of the Social Security system in 1935, the Federal Government has steadily expanded its role in providing for the elderly. The past couple of decades, in particular, have seen substantial growth in the role of the Federal Government in aiding senior citizens.

FEDERAL PROGRAMS FOR THE ELDERLY

The Federal Government has played a pivotal role in securing a decent standard of living for the nation's elderly. Federal efforts have been forthcoming on several fronts, with national legislation, foremost, playing a prominent role in establishing an income safety-net and an adequate level of health services for senior citizens. Also, many programs targeted at the low-income population have aided substantial numbers of senior citizens.

In addition to Federal Government establishment of programs benefiting the elderly, it also has provided the impetus, through program sponsorship and Federal monetary inducements, for state and local government program development. Federal requirements of state action have frequently galvanized state participation in defined problem areas of elderly concern. It should further be noted that Federal monies underwrite significant portions of existing state and local programs. Also, Federally-funded demonstration projects shape the contours of elderly policies and programs by determining the feasibility and effectiveness of various program options. Federal involvement, in encouraging greater coordination at the state and local levels, in addition, has given greater coherency to efforts to aid the elderly.

Federal outlays for the elderly have increased substantially in the post World War II period (See Table II-1 for current figures). ***The proportion of the Federal budget for elderly programs in 1985 was nearly double the elderly's share of the 1960 Federal budget, jumping from 15 to 28 percent. The***

TABLE II-1

FEDERAL OUTLAYS BENEFITING THE ELDERLY[1]

(In millions of dollars)

	Fiscal Year	
	1984 Actual	1985 Estimate
Medicare	$ 53,307.0	$ 61,391.0
Medicaid	7,435.0	8,508.0
Other Federal health	4,064.6	4,361.0
Health subtotal	**64,806.6**	**74,260.0**
Social Security	129,284.0	140,381.0
Supplemental Security Income (SSI)	2,832.0	3,169.0
Veterans compensation-pensions	5,031.0	5,425.0
Other retired, disabled, and survivors benefits	24,645.7	26,018.8
Retirement/disability subtotal	**161,792.7**	**174,993.8**
National Institute on Aging	100.0	125.0
Older American volunteer programs	91.0	103.0
Senior community service employment	321.3	318.9
Administration on Aging (Older Americans Act)	824.4	805.9
Subsidized housing	4,382.6	9,549.5
Section 202 elderly housing loans	595.0	514.4
Food stamps	610.0	615.3
Social services (Title XX)	366.2	369.0
Low income home energy assistance	622.0	630.0
Other miscellaneous	1,323.0	1,279.7
Other subtotal	**9,235.5**	**14,310.7**
Total elderly outlays	**$235,835.0**	**$263,564.5**
Percent of total Federal outlays	**27.7**	**27.5**

Source: *Aging America: Trends and Projections 1985-86,* U.S. Senate Committee on Aging (Washington, D.C.: U.S. Congress, 1985).

most current figures, fiscal year 1986, project outlays for the elderly exceeding $269 billion. Not only has there been a proliferation of elderly-oriented programs, particularly in the health field, but also the increases in elderly population size and Social Security benefits have significantly increased Federal expenditures on the elderly.

The traditions of Federal involvement with income maintenance and health care support constitute the mainstay of Federal engagement and are the most firmly established. ***Social Security and Medicare taken together comprise over $200 billion*** of the estimated $263 billion plus Federal elderly

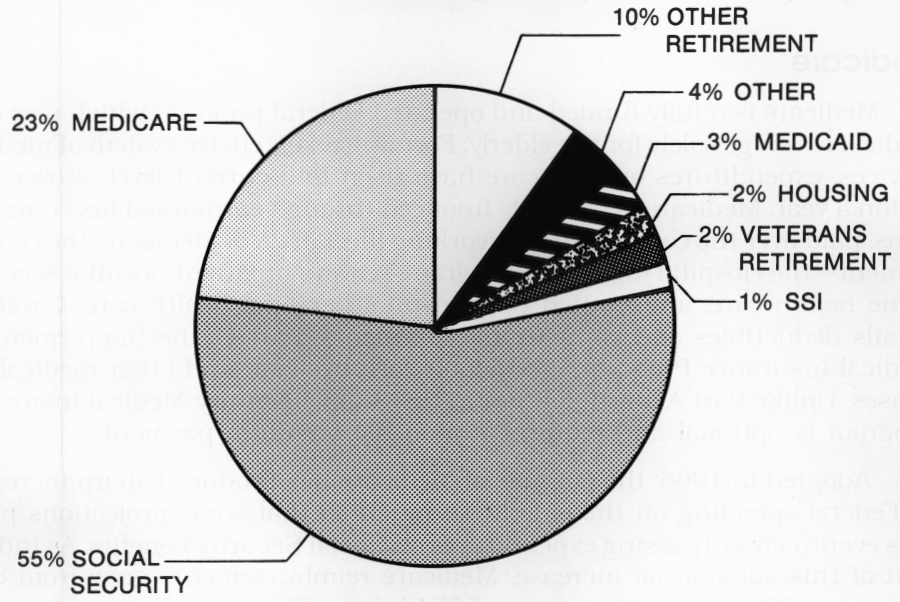
[1]Most estimates are based on Federal agency information and are for recipients aged 65 and over.

budget for fiscal year 1985. This amounts to over 75 percent of total Federal outlays for the elderly (See Table II-1 and Graph II-1).

Of present expenditures on the elderly, two-thirds provide for retirement income, a sharp decrease from 90 percent in 1960. The most salient factor causing this change is the growth in health care costs, with such expenditures rising from six percent of all Federal spending for the elderly in 1960 to approximately 30 percent in 1985.

GRAPH II-1

FEDERAL OUTLAYS BENEFITING THE ELDERLY
FISCAL YEAR 1985



Source: Executive Office of the President, Office of Management and Budget.

Social Security

Created in 1935, Social Security was enacted to provide a financial safety-net for workers and their dependents upon retirement. Payroll tax contribution to Social Security is mandatory for each working person and is paid by employers, employees, and the self-employed. Elderly benefits received under Social Security are based on average earnings over one's working life, with full entitlement realized at age 65. One hundred and forty billion dollars a year is paid to retired workers through this program.

Social Security allows individuals, from ages 65 to 69, to earn up to $8,160 a year without any reduction in benefits, with no limitation on earn-

ings from age 70 upward. Serving as a form of social insurance, Social Security is credited with reducing the elderly poverty rate by half—from 28.5 percent in 1966 to 12.4 percent for 1984. The Office of Management and Budget estimates that ***the poverty rate for the elderly would be 86 percent higher without Social Security, and that without transfer payments, 55 percent of the elderly would currently be living in poverty.***

Additional financial assistance is available for the elderly with low income through the Supplemental Security Income Program (SSI). Unlike Social Security, which bases benefits on contribution and age requirements, SSI is based on need, its availability contingent upon the individual falling below a designated income level and level of assets. Individuals receiving Social Security still are eligible for SSI if their Social Security benefit is below a set amount. Besides income supplements, the poor elderly are provided with housing support, food stamps, energy assis tance and various social services.[1]

Medicare

Medicare is a fully funded and operated Federal program which provides medical coverage solely for the elderly. Forming an extensive system of medical services, expenditures on Medicare have risen to a current level of over $70 billion a year. Medicare is basically financed through earmarked tax contributions, paid over the course of one's working life. Part A of Medicare, the central element—the Hospital Insurance Program—covers inpatient hospital services, home health care, and limited post-hospital personal health care. Coverage entails deductibles and co-insurance payments. Part B, the Supplementary Medical Insurance Program, is available for physician and other medical expenses. Unlike Part A, participation in the Supplementary Medical Insurance Program is optional and requires a monthly premium payment.

Adopted in 1966, the passage of Medicare has produced sharp increases in Federal spending on the elderly, so much so that some projections place it as eventually surpassing expenditures on Social Security benefits. As indication of this substantial increase, Medicare reimbursements grew from $5.3 billion in 1968 to a 1983 amount of $54 billion. The annual rate of financial increase was six times faster than the enrollment growth over the same period. Current estimates indicate that pension expenditures share of the Federal budget will bottom out, with elderly health care costs continuing to increase sizeably.

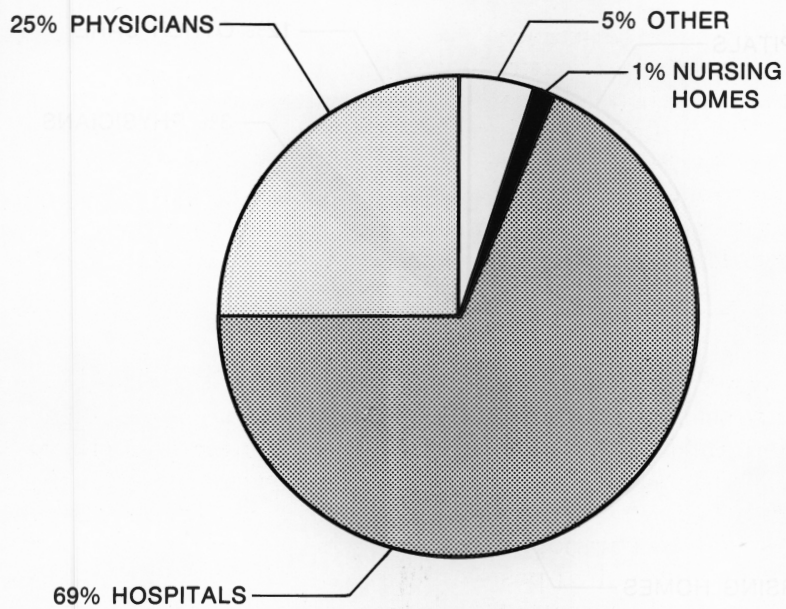
As Graph II-2 shows, ***approximately 70 percent of Medicare monies are for hospital expenses, with about one-quarter spent on physicians' fees.*** The combination of the two thus amounts to approximately 95 percent of total Medicare expenditures. Even nursing home care, an area of growing concern, amounts to only one percent of Medicare expenditures.

Despite the growth in Medicare outlay to over $70 billion in 1985 and Medicare increases in expenditures at an average annual rate of 18 percent

[1]The above discussion is based on U.S. Congress, Senate Special Committee on Aging *Developments In Aging*, Senate Report, 99th Congress, 2nd session.

GRAPH II-2

WHERE THE MEDICARE DOLLAR FOR THE ELDERLY GOES: 1984



Source: Health Care Financing Administration, Office of Financial and Actuarial Analysis.

over the last 12 years, out-of-pocket expenses by the elderly for health care costs have risen steadily. By 1981, elderly personal spending on health care constituted 15 percent of a senior's per capita income, with ***the elderly personally paying for a fourth of their total health care costs.***[2]

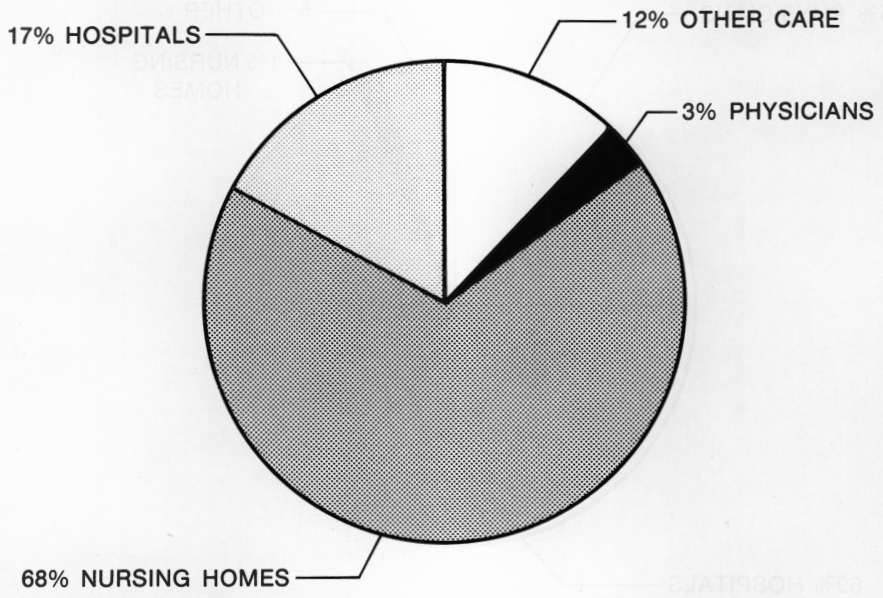
Medicaid

For the elderly poor, Medicare is supplemented by Medicaid—a Federally-sponsored program of medical assistance for all low-income persons. Originally conceived as an adjunct to Medicare, as Medicaid has evolved, it has greatly expanded in scope. Unlike Medicare, ***Medicaid is a joint Federal-state financed program. It is operated by state government and involves governmental reimbursement to health-care providers for medical services rendered to Medicaid recipients.*** No monies go to the clients themselves.

[2]The above discussion on Medicare relies on the Health Care Financing Administration, *Medicare Program Statistics: Medicare Enrollment, Reimbursement, and Utilization, 1983* (U.S. Department of Health and Human Services, June 1987).

GRAPH II-3

WHERE THE MEDICAID DOLLAR FOR THE ELDERLY GOES: 1984



Source: Health Care Financing Administration, Office of Financial and Actuarial Analysis.

The amount of Federal contributions to each state's Medicaid program is based on two considerations: the level of state expenditures on the program, with the Federal Government's financial support based on the size of state spending, and the state's overall level of income, with poorer states receiving higher Federal reimbursement rates. The range of Federal contributions for Medicaid varies from a minimum requirement of 50 percent of a state's total reimbursement costs to around 77 percent for the poorest states. For New Jersey, Federal reimbursement amounts to 50 percent of the State's Medicaid costs. Medicaid is the largest Federal grant-in-aid program.

Eligibility for Medicaid is based on a combination of low income and medical need, with two categories of eligibility serving as the basis for qualification: being aged, blind, disabled, thus falling under the criteria of Supplemental Security Income (SSI); and those families with dependent children, and thus eligible for the Aid to Families with Dependent Children Program (AFDC). Though most enrollees fall under the AFDC cash assistance program, the bulk of expenditures go for the aged, blind and disabled, with most funding directed at their long-term care. By 1984, Medicaid outlays had surpassed $35 billion, with close to $13 billion of Medicaid payments spent on elderly care. Of the Medicaid monies for the elderly, close to 70 percent goes to nursing

home care (Graph II-3). The proportion of Medicaid expenditures for the elderly has remained in the 37-38 percent range the past dozen years.

Older Americans Act Programs[3]

Central in the Federal effort to systematically address the needs of the nation's elderly are the programs of the 1965 Older Americans Act. As is true for much of elderly policy undertakings, this piece of legislation established an intergovernmental network encompassing Federal, state, and county-regional governmental institutions for handling elderly issues. At the national level, Title II of the Act established the Administration on Aging, within the Department of Health and Human Services, as the central Federal agency responsible for overseeing national policy for the elderly and ensuring implementation of the Act.

Operating under the twin purposes of promoting the elderly's personal independence and providing the necessary services for those senior citizens of greatest social and economic need, the Older Americans Act established a national *network on aging* to achieve these purposes. It encompasses the Administration on Aging at the national level, a state agency responsible for overseeing the mandates of the Act in each state, and *area agencies on aging*, responsible for service delivery at the county level.

Overseeing a budget (FY 1985) of over $700 million, the Administration on Aging (AOA) seeks to ensure the implementation of the programs for which Federal dollars have been earmarked, and that the state and area organizations responsible for implementation properly discharge their responsibilities (See Table II-2 for categories of expenditures). The Washington-based Administration on Aging and its 10 regional offices, guide and assist the state agencies in their implementation efforts.

Taken as a whole, the Older Americans Act funded programs constitute a coordinated and comprehensive service system of elderly support. The major strands of programs, serviced by this network on aging, under the Act, are:

- Nutritional services for the elderly (Title VII);
- Community service employment for older Americans (Title IX);
- The establishment and operation of multipurpose service centers (Title V);
- Elderly volunteer programs (Title VI);
- Grants for state and community programs on aging, with allotments to each of the states (Title III);
- Transportation services for the elderly (Section 109 of Title III);

[3]The following discussion of the Older Americans Act is based on *Developments in Aging: 1985 Volume 2* (U.S. Congress: 1986) and *New Jersey State Plan on Aging* (N.J. State Government, Division on Aging: 1986).

- Home services for the elderly suffering medical problems or incapacitation (Section 109 of Title III); and
- Legal services for older Americans (Section 109 of Title III).

The Older Americans Act requires the intergovernmental sharing of administrative responsibilities. This entails: 1) the establishment of a *state unit on aging* which oversees the regional and county-based *planning and service areas* (PSA); 2) the establishment of an *area agency on aging* (AAA) for each of these *planning and service areas* to handle service delivery; 3) the provision of Administration on Aging grants to state and area agencies in order to improve their institutional capacity.

In 1985, there were 57 state units on aging and 670 *area agencies on aging*, with more that 26,000 local nutrition and supportive service providers. Figures for 1985 show that more than 11,000 individuals were employed by the *area agencies*. The *area agencies on aging* receive their funding from the state unit and contract out most of the services, under a performance-based contracting system initiated in 1982. The *area agencies* also provide technical assistance and monitor the performance of the selected service providers.

The centerpieces of the Older Americans Act are *Title III-B* and *C supportive services* for needy senior citizens. Three components comprise *Title III-B:* 1) *access services* 2) *in-home services* and 3) *community and neighborhood services. Access services*, for the most part, entail contacting the

TABLE II-2

FY 1985 BUDGET
ADMINISTRATION ON AGING

Supportive Services and Senior Centers[1]	$265,000,000
Nutrition Services[1]	
Congregate Nutrition Services[2]	$336,000,000
Home-Delivered Nutrition Services	$ 67,900,000
Grants to Indian Tribes	$ 7,500,000
Training, Research, and Discretionary Projects and Programs	$ 25,000,000
TOTAL	$701,400,000

Source: *Developments in Aging: 1966-Vol 2: A Report of the Special Committee on Aging,* United States Senate.

[1]Up to 8.5% of the funds for Supportive Services and Senior Centers, and for Nutrition Services, may be used for Area Agency Activities.
[2]Includes funds set aside for evaluation activities.

TABLE II-3

TITLE III ALLOTMENTS BY STATE (FY 1986)

Sample States	Title III-B Supportive Services	Title III-C1 Congregate Meals	Title III-C2 Home-Delivered Meals
California	$ 23,304,833	$ 29,525,708	$ 5,971,314
Connecticut	3,547,556	4,497,336	908,977
Florida	15,542,581	19,692,543	3,982,420
Illinois	11,703,627	14,825,840	2,998,778
Massachusetts	6,631,153	8,403,613	1,699,076
Michigan	8,690,943	11,012,939	2,226,849
New Jersey	**8,228,656**	**10,427,319**	**2,108,399**
New York	19,670,762	24,922,091	5,040,169
Pennsylvania	14,404,582	18,250,935	3,690,834
TOTAL FOR ALL THE STATES:	$253,605,000	$321,447,000	$64,980,300

Source: *Developments in Aging: 1986-Vol 2: A Report of the Special Committee on Aging,* United States Senate, pp. 78-89.

elderly and linking them with the array of appropriate services. Of the *access services*, transportation was the most frequently utilized category of services. *In-home services* aid those infirm elderly who do not require critical medical attention. Included are such services as housekeeping, personal and home health care, and chore provision. *Community and neighborhood services* provide support within the community for those elderly who are largely self-sufficient but require some assistance. Some of the major services subsumed under this category are legal, residential repair, and health-care services. *Title III-B* reaches about nine million senior citizens, of which, for fiscal year 1984, 47 percent were low-income and 18 percent were racial and ethnic minorities.

Title III-C services provide meals to senior citizen nutrition centers and within seniors' homes. For fiscal year 1984, over 147 million congregate meals were provided for the elderly. ***Of a total Administration on Aging budget of over $700 million for fiscal year 1985, about $400 million, or 58 percent, was spent on nutritional services*** (Table II-3). Financing for congregate meals is also forthcoming from formula mandated state funding, Social Service Block Grants, other state and local funds, and other sources of Federal funds. ***Over 2.9 million seniors received meals at nutrition sites. In addition, about 611,000 homebound elderly received delivered meals in fiscal year 1984*** (this came to roughly 66.7 million meals).

Of a total of over nine million elderly receiving *supportive services* in fiscal year 1984, *over eight million received transportation services.* Among *in-home services* the largest category was *visiting/telephone reassurance* with close to a million recipients. It should be noted that *the "homemaker service" had over 650,000 recipients.* Within the *community service* category, the most utilized individual service was the health one with close to a million recipients (Table II-4).

TABLE II-4

ELDERLY RECEIVING SUPPORTIVE SERVICES FY 1984

A. **SERVICES**	**Persons Served**	
1. **Access:**		
Transportation	8,164,340	
Outreach	2,189,228	
Information and Referral	5,541,794	
Other	1,749,826	
2. **In-Home:**		
Homemaker	653,594	
Home Health Aid	178,002	
Visiting/Telephone Reassurance	969,696	
Chore Maintenance	255,691	
Other	338,236	
3. **Community Services:**		
Legal	490,405	
Escort	358,095	
Residential Repair/Renovation	86,579	
Health	977,000	
Other	9,981,245	
4. **Services in Care-Providing Facilities**	398,120	
B. **ESTIMATED PERSONS SERVED**		
1. Total Persons Served	9,126,122	(100%)
Greatest Social Need	4,503,912	(49%)
Greatest Economic Need	4,262,782	(47%)
2. Total Minority Served	1,597,589	(18%)
3. Racial/Ethnic Composition:		
American Indian/Alaskan Native	58,348	(1%)
Asian/Pacific Islander	133,053	(1%)
Black (not Hispanic)	1,034,958	(11%)
Hispanic	371,230	(4%)
White (not Hispanic)	7,528,533	(82%)

Source: *Developments in Aging: 1986-Vol. 2: A Report of the Special Committee on Aging,* United States Senate.

Housing Programs

A diverse array of housing programs exists which directly and indirectly aid the elderly. The chief role is played by the United States Department of Housing and Urban Development (HUD). A distinction must be made between those programs which are targeted directly at low-income individuals, in some cases specifically the elderly, and those programs which have the general purpose of neighborhood renewal, with elderly residents often the beneficiaries of such programs.

Two types of housing programs directly serve the low-income elderly: one set provides rental subsidies for low-income groups including senior citizens, the other underwrites construction of facilities servicing low-income people. Of the former, Section Eight of the 1983 Housing Act is the largest Federal housing assistance program. The program is designed to enable low-income individuals to afford private rentals by providing a supplement to the recipient that makes up the gap between the market value of the rent and what the recipient can afford to pay. Figures for 1983 show that of the roughly two million units under the program, 41 percent were occupied by the elderly.

Another major program is Section 202 of the 1983 Housing Act which provides low-interest loans for developers to construct or rehabilitate housing for the elderly and handicapped. Institutional participation is limited to non-profit organizations. By the end of 1983, over 160,000 units had been built or were awaiting completion. Occupants of the overwhelming majority of these units receive rent subsidies under Section Eight. Many of these facilities contain congregate dining areas, and provide supportive services such as health and transportation for their elderly residents. The elderly, availing themselves of Section Eight or Section 202, pay upwards of 30 percent of their income for rent.

Also available for those of low-income, which includes the elderly, are public housing. The formula for rent payment here is identical to that of Section Eight. ***Of the total public housing units at the end of 1983, more than 500,000, comprising 43 percent of the total, were occupied by the elderly.***

Another type of program financially underwrites the mortgages for construction of facilities intended to service the elderly. Section 231, under HUD, insures the mortgages of organizations involved in the construction or rehabilitation of unsubsidized rental apartment buildings for the elderly. By the beginning of 1984, 513 projects, comprising about 68,000 units, had mortgage loans insured by HUD. Another program, Section 221, operates similarly to Section 231, with the exception that it is available for low and moderate income people, not just the elderly. Ten percent of the nearly 1.2 million units insured through 1983 are occupied by elderly residents.

Included under Section 221 are congregate housing—apartment living arrangements where meals are provided in common and housekeeping services are furnished. HUD also underwrites mortgages for the construction and rehabilitation of nursing homes, intermediate care facilities (both under Section 232) and hospitals (Section 242). In order for HUD to financially under-

write the mortgages of nursing home and intermediate care facilities, a state agency must certify the need for such an institution. The vast majority of residents of such facilities are elderly. By 1984, 209 hospitals with over 56,000 beds have had their mortgages underwritten by HUD under Section 242.

Another set of housing programs, which have as their objective the redevelopment of communities and neighborhoods, benefit elderly residents without necessarily targeting them for special aid. The two chief policy instruments for redevelopment are Community Development Block Grants (CDBG), which address problems of residence in areas of slums and blight, and Urban Development Action Grants (UDAG), which are directed at economic development of economically distressed communities.

Community Development Block Grants (CDBG) provide funding for low and moderate income housing in order to reduce neighborhood blight. Most prominent in addressing the needs of the elderly are project funding for: housing rehabilitation, weatherization assistance, establishment of senior citizen centers, rehabilitation of neighborhood facilities, and provision of social services. To take one example, weatherization assistance—figures up to 1986 indicate about 1,500,000 low-income homes were weatherized, almost half were occupied by the elderly.

Urban Development Action Grants (UDAG) were competitively awarded to cities and urban counties meeting economically distressed criteria. While generally going to build shopping centers and public facilities, Urban Development Action Grants have provided for construction of nursing homes, geriatric centers and apartment buildings housing the elderly.

SUMMARY

The Federal Government plays a major role in aiding the elderly. It does so in two ways: 1) by providing direct benefits to senior citizens in several areas and 2) by conjoining with state and local governments to provide various services. Regarding the latter role, the Federal Government provides financial assistance for these programs' operations. Federal Government outlays for the elderly exceed $269 billion and constitute 28 percent of the Federal budget.

Chief among the programs operated exclusively by the Federal Government are Social Security and Medicare. The Social Security program, underwritten by a payroll tax, serves as an economic safety-net for workers after retirement. It presently pays out $140 billion a year. Studies estimate that the poverty rate for the elderly would be 86 percent higher without Social Security.

Medicare provides basic health care coverage for the elderly, with hospital coverage forming 70 percent of Medicare expenditures. It is financed through mandatory wage deductions. The Federal Government spends $60 billion a year on Medicare.

Other programs aid the elderly through joint Federal-state endeavors. Chief among these are Medicaid and the programs under the Older Americans Act. Medicaid is financed by both the Federal and state governments. It is operated by state government and financially underwrites medical services for the indigent. Close to 40 percent of Medicaid expenditures are for senior

citizens. About 70 percent of Medicaid monies spent on aiding senior citizens is used for nursing home care.

The Older Americans Act provides an array of services for senior citizens. The programs are, by-in-large, operated by county government, with the participation of Federal and state governments. The four major components of the program are *access services, nutritional services, in-home services,* and *community and neighborhood services.* Of a total annual expenditure of over $700 million, over $400 million was spent on nutritional services. Transportation services, with the largest number of recipients, serves over eight million senior citizens.

In addition, the Federal Government operates a number of housing programs which provide rental assistance to low-income groups and financially underwrite construction of housing facilities for low-income people. Of the two million units available under the rental assistance program, over 40 percent were occupied by senior citizens.


VOLUNTEER

CHAPTER III
STATE PROGRAMS

INTRODUCTION

New Jersey Government ranks among the forefront of states in addressing the needs of elderly residents. From its establishment of the State Division on Aging in 1957—the first state in the country to form a state agency to focus specifically on elderly problems—New Jersey has shown innovativeness and commitment in attending to the problems of its elderly citizens. Of particular note is the inauguration of the Casino Revenue Fund in 1976 which was established as a funding source to partially defray the costs of residential and pharmaceutical expenses for the elderly and disabled. Recent efforts have been directed at establishing an expanded system of in-home and community care for the frail elderly that would leave nursing home care exclusively for those requiring institutionalization.

The overall result of these initiatives has been the establishment of a variety of programs by New Jersey Government that aid the elderly directly or address the needs of a larger population, thereby also encompassing the elderly. Though there are New Jersey State agencies that give cohesion and direction to meeting the needs of the elderly, the overall State administrative network, and its array of programs aiding senior citizens, is highly fragmented and disconnected.

In order to understand the role played by New Jersey local governments regarding the elderly, knowledge is required of how local efforts are connected to State and Federal policy. In many matters, Federal, State and county activities on behalf of the elderly are conjoined as a consequence of the initiatives and funding requirements of the State and Federal governments. The most salient component of joined intergovernmental efforts are those programs emanating from the *Older Americans Act.*

STATE RESPONSIBILITIES

State responsibilities on elderly matters take different forms. In essence, what is in place is a three-tier system of State institutional mechanisms and programs that address elderly needs. One tier consists of a set of programs, based on interconnected Federal and State initiatives and funding, which is targeted at the elderly and provide various support services. These programs are overseen by the State's Division on Aging. A second tier consists of State run programs for New Jersey's needy, which includes the elderly as a subset of recipients, with Federal Government involvement defined in terms of partial funding and mandates. By far, the largest program in this category is the Medicaid program. A third tier consists of a set of *Casino Revenue Fund* sponsored assistance programs, mainly encompassing tax credits or tax deductions, which direct payments to senior citizens based on services utilized.

While there has been somewhat of a commingling of these three tiers, their distinctive features make it useful to conceptualize State programs for the elderly in these terms.

Expenditures for State funded programs for the elderly are expected to rise from a 1985 level approaching $450 million to an estimated 1989 level of about $700 million. Projections for State fiscal year 1989 show an estimated $692 million in State expenditures for elderly programs of which about $533 million will go for health and welfare programs. This means that ***77 percent of total elderly funding will be for health and welfare services.*** The only other major category of elderly program expenditures is utility relief with a projected $114 million in State expenditures. This latter category amounts to 14 percent of the overall 1989 State budget for elderly programs (Graph III-1).

New Jersey State Division On Aging[1]

The central force behind the State effort to ensure that New Jersey's senior citizens' needs are met is the State Division on Aging. Formally entrusted with the responsibility of overseeing elderly services, the Division on Aging's efforts are the resultant of Federal Government's Older Americans Act and New Jersey Government defined goals. The Division's role is to ensure that State and Federal Government established objectives are achieved. The New Jersey Division on Aging also serves as a conduit to the State and its communities for Federal funding and grants for elderly programs.

In establishing the Division on Aging in 1957 by legislative act, New Jersey became the first state in the Union to form an agency with an exclusive focus on questions concerning the elderly. With the passage of the Older Americans Act, in 1965, the Act's requirement that states have a state agency to administer Federally-funded elderly programs led the rest of the states to follow suit.

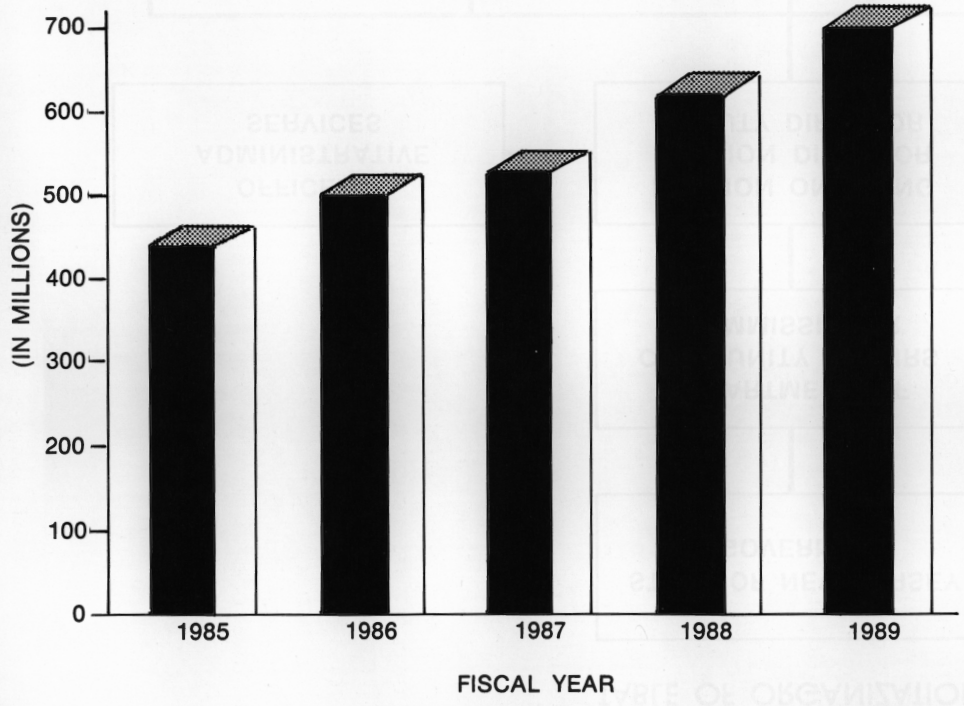
The Division on Aging provides cohesion and direction to the servicing of the State's elderly. Chief among the Division's functions is the coordination of intergovernmental efforts at the Federal-State, intra-State and State-county levels. Located within the State's Department of Community Affairs, ***the Division is entrusted with both the administrative function of coordinating ongoing intergovernmental efforts and the policy function of developing or modifying programs to address unmet needs.*** Within its coordinating role, the most critical aspect of this function is to ensure that the statewide network of County Offices on Aging fulfill the objectives of the Older Americans Act. Thus the Division on Aging constitutes the vital link in the Federal-State-county nexus, providing both funding and oversight of the county offices.

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[1]Much of this material is based on *New Jersey Department of Community Affairs, Division on Aging: History, Functions, Organization* (Trenton: New Jersey State Government, 1986).

GRAPH III-1

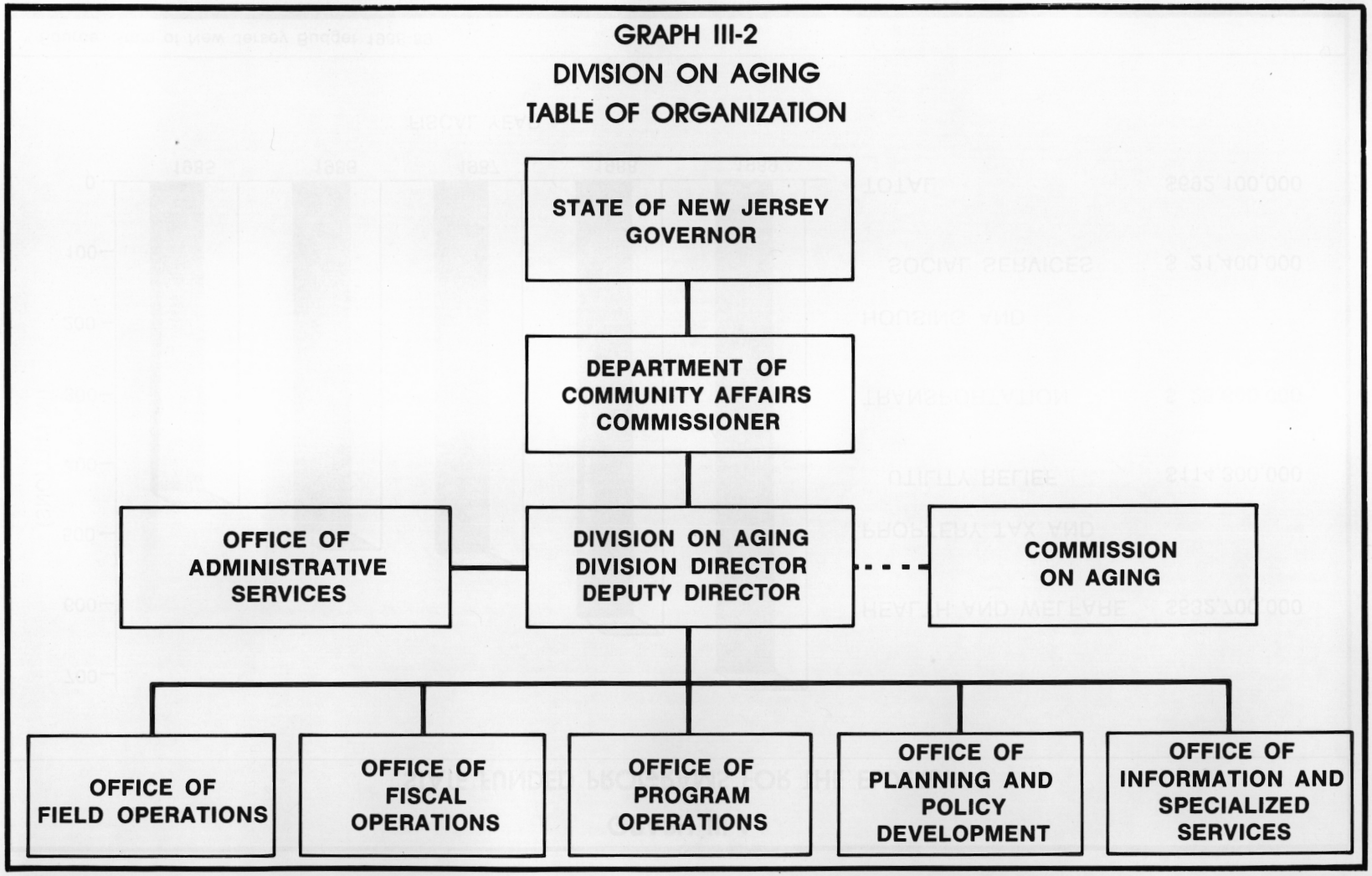
STATE FUNDED PROGRAMS FOR THE ELDERLY



HEALTH AND WELFARE	$532,700,000
PROPTERY TAX AND UTILITY RELIEF	$114,300,000
TRANSPORTATION	$ 23,600,000
HOUSING AND SOCIAL SERVICES	$ 21,400,000
TOTAL	$692,100,000

Source: State of New Jersey Budget 1988-89.

GRAPH III-2
DIVISION ON AGING
TABLE OF ORGANIZATION



In line with Older Americans Act directives, the Division on Aging discharges two major kinds of responsibilities: 1) it performs an "advocacy role," representing the interest of New Jersey senior citizens before the other administrative and elected bodies of State, local, and Federal Government, and 2) it serves as administrative architect and coordinator in the effort to refine the service delivery system so as to best meet elderly needs at the community level. In its advocacy role, the Division on Aging seeks to ensure that State/county programs and actions incorporate elderly concerns. Its role as administrative locus of the multi-organizational service delivery system requires of the Division that it coordinate the efforts of county, State, and Federal institutions to provide community-based services for New Jersey's elderly.

State legislative mandate formally authorizes the Division to carry out the following functions: 1) determine the needs of senior citizens, 2) oversight of the resources necessary to implement elderly programs, 3) planning and coordination of the State's senior citizen programs, 4) provision of leadership in achieving program purposes, 5) dissemination of information regarding senior citizen needs, and 6) facilitating State interdepartmental and Federal-State cooperation to meet the objectives of the Older Americans Act. Because of national statutory provisions requiring maximum integration of intergovernmental efforts, State statutory language closely parallels that of the national Older Americans Act.

The passage of the Older Americans Act (with its resulting programs and funding), corollary actions by New Jersey to ensure State administrative consistency with the Older Americans Act, the establishment of county offices to address elderly needs, as an aggregate, these actions produced an intergovernmental administrative system to meet the needs of the elderly. Cementing the system is the Division on Aging, the middleman between the Federal Government and New Jersey counties and the go-between in State Government and Federal level interactions.

Programs overseen by the Division on Aging largely consist of *supportive services* (under Title III-B of the Older Americans Act). Within this category are services enhancing the mobility of senior citizens, enabling them to leave their homes and participate in outside activities: included here are transportation and escort services. Another set of services entail in-home support for the frail elderly: included among these are home health aides, visiting nurses, and chore aid. Other supportive services include legal aid and support for senior citizen centers. Title III C-1 provisions of the Act, which include ***congregate nutrition services*** and C-2 ***home delivered nutrition services,*** give the Division oversight responsibilities over the provision of meals for the elderly within community facilities and home-delivered meals for the homebound elderly.

Other major areas of Division on Aging involvement include personnel training, research and data collection, and initiation of demonstration projects. The Division also operates New Jersey congregate housing's *personal service* program for the frail elderly living in subsidized housing. Through monies from the Casino Revenue Fund, the Division contracts the following services for the elderly in congregate housing: meals, housekeeping, laundry

and other personal services. The Division directly administers the program helping the low-income elderly find part-time work. Also, the Division is involved in developing a health educational program for the State's senior citizens.

TABLE III-1

SUPPORTING SERVICES STATE SUMMARY FOR 1987

SERVICES	Number Services	Clients Served		
Supportive Services	**Provided 1987**	**Total**	**Low Income**	**Minority Population**
Information/Referral	849,234	321,744	38,744	12,854
Outreach	84,471	47,417	9,238	4,075
Transportation	1,655,563	66,788	7,714	2,760
Homemaking	50,991	940	452	153
Visiting Nurses	8,251	1,236	454	139
Home Health Aide	61,192	1,898	305	51
Chore	7,967	636	241	47
Friendly Visiting	25,798	2,747	1,005	300
Telephone Reassurance	224,741	2,814	628	313
Respite Care	26,478	369	191	34
Hospice Care	10,352	272	90	29
Legal Assistance	30,922	9,897	2,546	634
Ombudsman	1,515	345	21	8
Protective	26,421	1,887	146	111
Advocacy Assistance	42,925	10,079	1,731	611
Health/Physical	115,601	27,301	7,820	3,180
Health/Mental	16,159	4,614	1,184	406
Health/Dental	6,914	2,068	306	108
Volunteer Activities	337,576	7,663	1,800	658
Escort	2,220	591	302	283
Shopping	30,518	1,953	784	378
Home Repairs/Maintenance/ Renovations	13,127	1,892	625	155
Employment Assistance	14,272	6,819	195	1,212
Housing Assistance	8,899	3,755	1,040	381
Education and Training	45,000	52,952	5,873	2,128
Counseling	28,292	7,627	2,329	916
Language Translation and Interpretation	11,783	3,173	2,140	2,250
Emergency Assistance	1,888	822	254	153
Socialization/Recreation	128,134	213,667	10,049	3,047
Adult Day Care	402	12	8	1
SUPPORTIVE SERVICES TOTAL	**3,867,606**	**803,978**	**98,215**	**37,375**
Home Delivered Meals	2,014,583	18,614	6,658	2,187

SOURCE: N.J. State Division on Aging, *Title III Program Systems Summary Tracking Report* (April 1988).

New Jersey Commission on Aging

With the 1957 creation of the Division on Aging, the State Legislature concomitantly established the *New Jersey Commission on Aging.* The Commission, which is composed of nine members, maintains a liaison between groups representing the elderly and State Government offices that act on elderly issues. The Commission largely plays an advisory role, bringing matters before the Division on Aging, the Governor and the State Legislature. In 1981, the Commission formed the *Task Force on Legislative Concerns,* a body made up of various statewide senior citizen groups, which meet periodically to review the outstanding problems of New Jersey's elderly and advise the Commission on senior citizen priorities.

NEW JERSEY PROGRAMS FOR THE NEEDY

Medicaid

A second tier of State undertakings consists of programs operated by State agencies for the needy and indigent. Large numbers of low-income elderly fall under the purview of these programs. By far, the most important program is that of *Medicaid,* which is overseen by the New Jersey Department of Human Services.

Within New Jersey, ***Medicaid serves approximately seven percent of the State's population—more than 500,000 individuals. Medicaid expenditures surpassed 1.2 billion dollars in 1984, up sharply from $124 million in 1970.*** The annual growth rate between 1975 and 1985 has averaged about 12 percent, with rising costs largely attributable to increases in health care costs and expanded service usage rather than increases in the number of clientele. In fact, the number of New Jersey's Medicaid recipients actually has declined from the peak year of 1976, down by some 100,000 enrollees when compared with 1985 levels. Medicaid expenditures presently make up seven percent of New Jersey's State budget.

For State fiscal year 1987, ***the three major categories of New Jersey Medicaid expenditures were nursing home care ($473 million), hospital inpatient costs ($356 million), and prescription drug payments ($103 million).*** Thus, out of Medicaid expenditures of $1.2 billion, approximately 36 percent was spent on nursing home care, 30 percent on hospital inpatient services, and nine percent on prescription drugs. While good numbers of nonelderly made up the clients of the latter two categories, the overwhelming numbers of the nursing home clients were senior citizens. Another major category of Medicaid heavily oriented toward the elderly is *home health care,* with $32 million in expenditures.

Data for New Jersey for 1986 indicate that the the SSI group constitutes about 30 percent of Medicaid recipients yet consume about 52 percent of Medicaid expenditures (Graph III 3&4). The majority of elderly funding is spent on nursing homes services, 68 percent, and general hospitals, 17 percent. About 75 percent of New Jersey's 1984 Medicaid costs, as well as most of the program's growth, went to these two institutional services.

TABLE III-2

CONGREGATE MEALS AND SERVICES STATE TOTAL FOR 1987

	Number Services Provided 1987	Clients Served Total
Congregate Meals Served	3,266,336	39,480
Minorities Served	193,217	4,555
Low Income Minorities	114,148	1,485
Low Income Served	417,301	13,780
Supportive Services—Congregate Sites		
Transportation	686	5,326
Outreach	800	1,524
Escort	156	37
Information and Referral	1,583	4,837
Counseling	223	1,488
Shopping Assistance	157	560
Nutrition Education	526	21,480
Recreation	3,311	11,761

SOURCE: N.J. State Division on Aging, *Title III Program Systems Summary Tracking Report* (April 1988).

Medicaid also plays an important role in financially propping up health institutions. Medicaid paid for roughly half of New Jersey's nursing home costs, and contributes substantial amounts to underwriting psychiatric hospital use and home health-care. In addition, New Jersey's Medicaid program has also been a major force in the effort to redirect nonacute care for the elderly away from institutionalization toward home and community-based care.[2]

Medicaid's Involvement With Home Support Services

One of the most significant recent trends is Medicaid underwriting of "home support" services in New Jersey. This action forms part of a national movement toward financing and encouraging the growth of "home support" services.

Over the past couple of decades, public services for the elderly have shifted in the direction of aid that helps the frail elderly remain in their homes rather than being subject to institutionalized care. This policy direction is based on three primary considerations:

1) realization that the elderly desire to retain their independence and

[2]The above section on Medicaid borrows heavily from Beer, Nancy G. and John R. Lago *The Dynamics and Directions of New Jersey Medicaid* (Princeton: Princeton Urban and Regional Research Center, 1987).

community attachment as long as possible and that government should act in accordance with these wishes;

2) growing realization that chronic care needs must be addressed; and

3) the financial consideration that public monies may be saved if services are offered in-home, thus avoiding the exorbitant cost of institutional care.

The latter consideration stems from the great disparity in costs between home care and institutionalized care.

One aspect of community-based care is *adult day care.* This service entails care and supervision in a designated facility, a portion of each day, for senior citizens whose physical or mental impairment make complete independent living impossible. Adult day care consists of two different types of services—*social day care* and *medical day care,* with Medicaid providing reimbursement for the latter. Social day care offers a sheltered environment, one meal a day, and structured social activities. Medical day care provides the above noted services and, in addition, therapeutic and physical rehabilitative services, personal care, and health screening and counseling.

Medicaid expenditures for medical day care came to $3.6 million in 1987, up from $2.8 million the previous year. There currently exist 50 medical day care centers in the State. Participation in the program averaged 800 individuals a month in 1987. Priority for admittance is given to elderly residents who are most socially and economically disadvantaged.

The movement toward provision of in-home benefits has been advanced by the decisions of the Federal Government to allow Medicaid waivers for in-home care services and the New Jersey Government decision to provide funding for selected in-home care services. While numbers of these programs constitute waivers, there is no doubt that home care has become established as a sector of services available for senior citizens and will undoubtedly increase in funding and in scope in future years.

The growing use of in-home services underlies the effort to deal with the chronic illnesses of the elderly, a policy concern that has customarily been overlooked, given the traditional focus on acute care. With the growing numbers of elderly of advanced years, the need for personal care and home management can only increase. Heightening this need is a society in transition, in which physical dislocation produces the absence of close family and friends who traditionally have looked after the frail elderly.

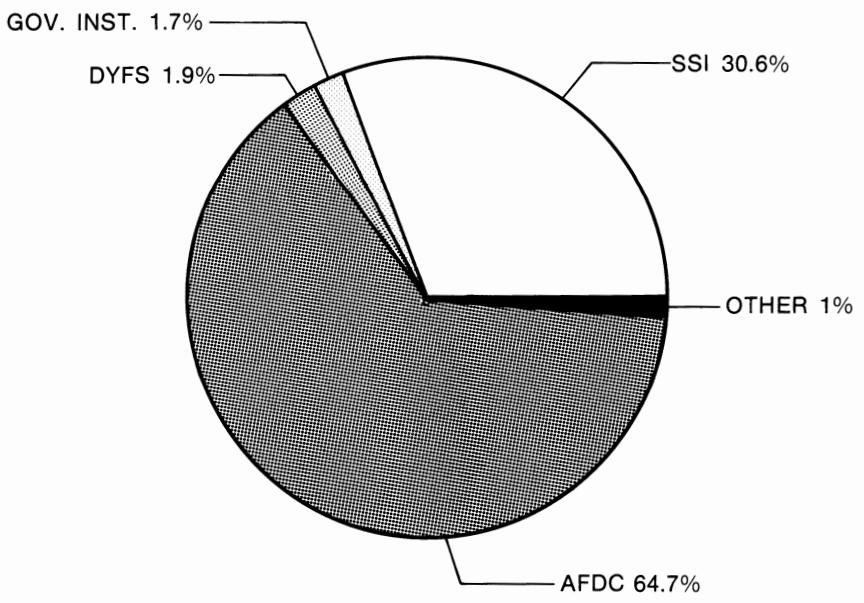
National data show the decline in ability to maintain self-care with advanced years. The inability to carry out a major physical activity increases from 15 percent of the elderly, age 65 to 74, to 22 percent for those 75 and over. ***For the age cohort 85 and over, 31 percent report an inability to perform a major physical activity because of a chronic condition.*** The elderly in need of personal care and home management assistance jumps from 16 percent of people 75-85 to 39 percent for those 85 of age and over. The Senate Special Committee on Aging estimated recently that three-fifths of the elderly, 85 and over, will require long-term health care. ***The Division on Aging projects from the national data that 166,000 (18 percent) of New Jersey's 65***

and over population have severe functional disabilities, and by the year 2000 there will be 213,000 elderly New Jerseyites in need of daily assistance.[3]

Both Medicaid and Medicare funding pay for *home-care*—services that provide personal care and performance of minor household tasks. In fact, Medicare (under Title XVII of the Social Security Act) is the major source of funding for home-health care, with its payments for home health services extending to over 46,000 elderly at a cost, in 1982, of $931.56 per person. However, the orientation of Medicare coverage is on those recuperating from acute care problems. The thrust of Medicare's home health care reimbursements is toward skilled nursing care or physical and speech therapy, with a physician's certification of need necessary for eligibility. Also, Medicare sponsors reimbursement for hospice benefits for the terminally-ill.

GRAPH III-3

NEW JERSEY MEDICAID PROGRAM RECIPIENTS BY CATEGORY STATE FISCAL YEAR 1986

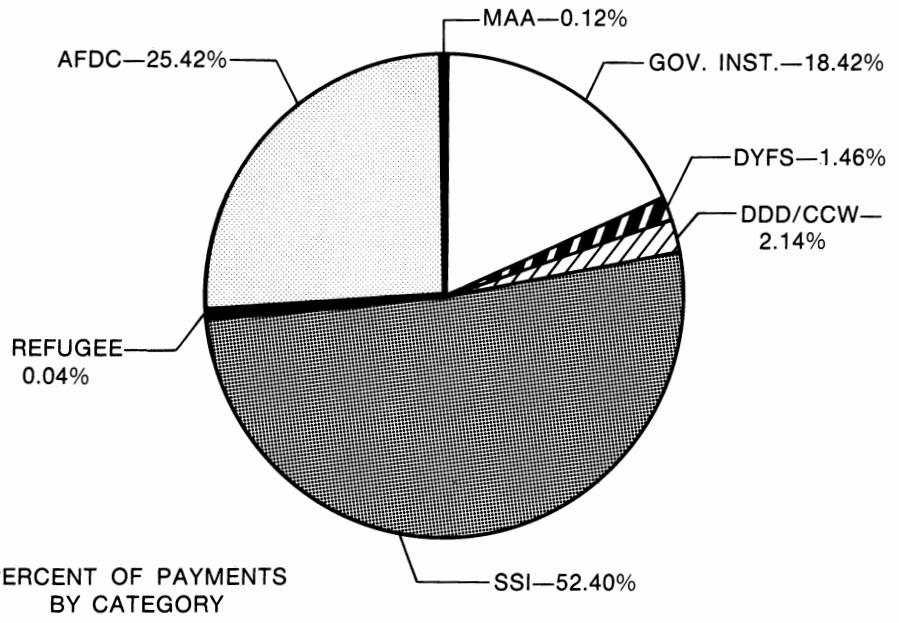


Category Other includes MAA, Refugee, and DDD/CCW/SRS.

Source: New Jersey Department of Human Services, "New Jersey Medicaid Fiscal Year 1986 Annual Report," (Trenton, New Jersey, 1987)

[3]The data reported here are based on 1980 National Center for Health Statistics data and are noted in the Division on Aging's *Aging in New Jersey: Sixty-Five and Over*, (Trenton: New Jersey State Government, 1986), p. 35.

GRAPH III-4
NEW JERSEY MEDICAID EXPENDITURES
STATE FISCAL YEAR 1986
PERCENT OF PAYMENTS BY CATEGORY



Payments exclude off-system adjustments, HMO Capitation, MP Plan payments.

Source: New Jersey Department of Human Services, *New Jersey Medicaid Fiscal Year 1986 Annual Report* (Trenton, New Jersey 1987)

Geriatric Evaluation Program[4]

In 1987 the New Jersey Department of Health initiated a *geriatric evaluation program.* The program's purpose is to provide comprehensive diagnostic assessments and health promotional sessions for senior citizens, thereby reducing institutionalization. The program is operated by seven teaching hospitals and medical centers in the State with more planned.[5] Current funding for the program is $713,000.

In the first six months of the program over 200 assessments had been completed. Numbers of health promotional activities, largely entailing health

[4]Department of Health, Gerontology Program, *Report of Hospital Based Geriatric Evaluation Program* (Trenton, N.J.: State Government, 1988).

[5]Atlantic City Medical Center (Atlantic City), Memorial Hospital of Burlington County (Mt. Holly), Morristown Hospital (Morristown), Newark Beth Israel Medical Center (Newark), St. Francis Medical Center (Trenton), St. Joseph's Hospital and Medical Center (Paterson) and Warren Hospital (Phillipsburg).

screenings and educational seminars, have been carried out, with over 600 senior citizens participating. These promotional activities have been held in nursing homes, senior citizen centers, nutrition sites, and health fairs. The program also has provided informational and training sessions for health care professionals.

New Jersey Uncompensated Care Trust Fund[6]

In 1980 New Jersey initiated a program to publicly fund acute hospitals for their uncompensated care. Governmental payment is forthcoming for both inpatient and outpatient health services and goes to pay for individuals provided "charity care" and the poor and near-poor who are either underinsured or uninsured. The elderly constitute a subset of the population which receive health care treatment based on Trust Fund financing. Elderly recipients of care through Trust Fund financing have medical bills that are unreimbursed by Medicare and are above the Medicaid income eligibility level.

Financing of the system occurs through a surcharge on all purchases of hospital-based health care. This includes government paid care (Medicare and Medicaid), employers' paid health coverage, and individuals purchasing their own insurance. Monies collected are placed in the State Trust Fund and remitted to New Jersey hospitals based on their individual amount of uncompensated care. Figures for 1987 indicated a total of $345 million in payment to hospitals for uncompensated care.

CASINO REVENUE FUND PROGRAMS

A third tier of the State service system for New Jersey's elderly are the set of programs underwritten by the Casino Revenue Fund. The Casino Revenue Fund was created to aid senior citizens and the disabled, upon State citizens' approval of casino gambling within Atlantic City in 1976. The Casino Control Act (N.J.S.A. 5:12-1 et seq.) established an eight percent tax on the casinos' gross revenue which would go into the Casino Revenue Fund. ***Revenues raised from casino gambling have grown since 1978 to a current level of around $250 million.***

Monies raised from the Casino Revenue Fund have underwritten an assortment of programs, with an initial set forthcoming following the passage of the casino gambling referendum, and a second grouping of programs established upon the 1981 approval by the voters of a constitutional amendment. The original 1976 casino gambling referendum required that the monies raised be used solely for the purpose of providing senior citizens and the disabled with reductions in "... property taxes, rentals, telephone, gas, electric, and municipal utilities charges..."[7]

The passage of the 1981 constitutional amendment expanded the areas of authorized spending from casino revenue profits to include health and

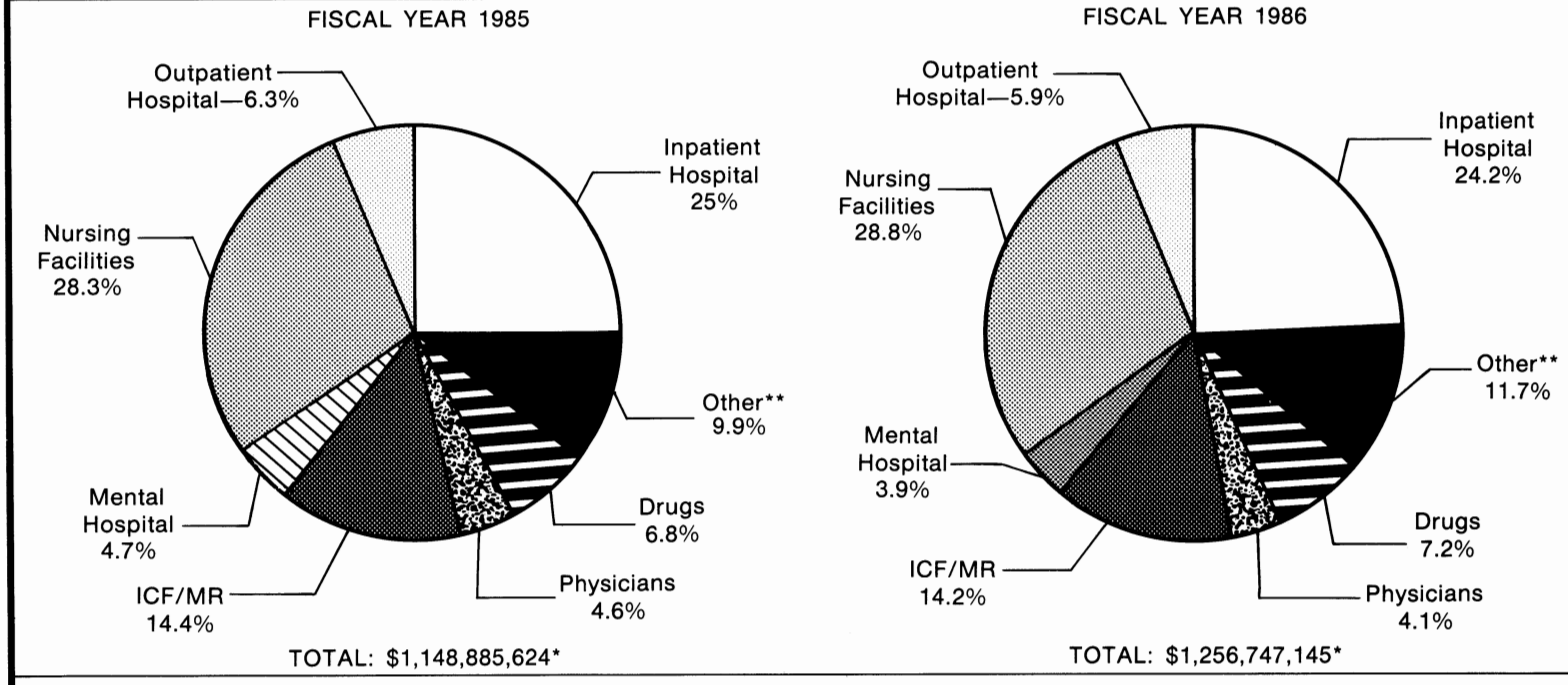
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[6]New Jersey Department of Health, *New Jersey's Uninsured and Hospital Uncompensated Care* (Trenton: N.J. State Government, 1988).

[7]New Jersey Constitution, Article 4, §7, paragraph 2, subparagraph D.

GRAPH III-5

NEW JERSEY MEDICAID EXPENDITURES
Percent of Total, By Type of Service



*Payments exclude off-system adjustments.

**Other includes payments for Home Health, Dentist, Podiatrist, Optometrist, Clinic, Medical Day Care, Lab and X-Ray, Optical Appliances, Prosthetics, Medical Supplies, Transportation, CCPED, Model Waivers, Personal Care, MP Plan, Medicare "B" Premium and HMO Capitation.

Source: New Jersey Department of Human Services, *New Jersey Medicaid Fiscal Year 1986 Annual Report* (Trenton, New Jersey, 1987)

TABLE III-3

MEDICAID PAYMENTS BY SERVICE, COMPARISON OF FISCAL YEARS 1985 AND 1986

Type of Services	FY 1985	FY 1986	Percent Change 1985-1986
TOTAL	**$1,148,885,624**	**$1,256,747,145**	**9.39**
LONG TERM CARE: TOTAL	**$ 544,472,151**	**$ 596,391,163**	**9.54**
SNF*	34,495,355	37,475,742	8.64
ICF/A*	226,668,563	254,514,733	12.28
ICF/B*	63,967,080	69,704,294	8.97
County Nursing Homes	80,703,222	93,848,293	
Mental Hospitals	54,017,251	49,295,659	-8.74
County	18,282,668	16,178,530	
State	35,344,666	32,150,756	
ICF/MR*	165,323,902	177,952,302	7.64
Residential Care	0	7,448,433	N.A.
OTHER CARE: TOTAL	**$ 589,690,368**	**$ 644,933,852**	**9.37**
Inpatient Hospital	286,826,038	304,440,096	6.14
Outpatient Hospital	71,915,322	74,351,303	3.39
Home Health	22,474,918	26,376,090	17.36
Physician	52,906,840	52,031,358	-1.65
Dentist	21,384,013	20,613,836	-3.60

New Jersey State Library

Podiatrist	1,128,927	1,142,575	1.21
Optometrist	2,055,261	1,960,585	-4.61
Drugs	78,683,145	90,540,626	15.07
Clinic	10,507,376	11,793,789	12.24
Medical Day Care	2,381,394	2,807,527	17.89
Lab and X-Ray	2,630,021	2,464,152	-6.31
Optical Appliances	2,568,598	2,451,287	-4.57
Prosthetics	1,158,961	1,226,862	5.86
Medical Supplies	5,919,268	7,854,246	32.69
Transportation	6,532,519	7,775,056	19.02
CCPED**	2,360,752	7,284,899	308.56
DMR/CCW***	15,955,711	23,842,897	49.43
Model Waiver #1	7,575	27,810	367.13
Model Waiver #2	0	114,517	N.A.
Personal Care	1,502,190	4,844,454	322.50
MP Plan****	791,539	989,887	25.06
Medicare "B" Premiums	**14,294,437**	**14,942,004**	**4.53**
HMO Capitation	**428,668**	**480,126**	**12.00**

N.A. = Not Applicable

*SNF—Skilled Nursing Facilities; ICF/A—Intermediate Care Facility 1A; ICF/B—Intermediate Care Facility 1B; ICF/MR—Intermediate Care Facility (Mental Retardation).
**Community Care Program for Elderly and Disabled
***Division Mental Retardation/Community Care Waiver
****Medicaid Personal Physician Plan

Source: *Medicaid Fiscal Year 1986 Annual Report,* State of New Jersey, Department of Human Services.

TABLE III-4

New Jersey Medicaid Expenditures By Category Of Recipient

Category	Payments* FY 1985	Payments* FY 1986	% Change	Recipients FY 1985	Recipients FY 1986	% Change
All Groups	**$1,147,665,417**	**$1,255,277,132**	**9.0**	**280,525**	**282,977**	**1**
SSI-Related—Total	**$ 585,127,289**	**$ 657,812,477**	**12.0**	**82,506**	**183,149**	**5**
Aged	351,844,531	401,183,189	14.0	40,011	171,040	5
Disabled	230,056,405	252,991,068	10.0	41,804	8,130	5
Blind	3,226,353	3,638,220	13.0	691	3,979	6
Medical Assistance to Aged	**2,019,248**	**1,506,699**	**-25.0**	**309**	**86,619**	**-29**
Governmental Institutions—Total	**$ 221,679,609**	**$ 231,148,596**	**4.0**	**5,222**	**4,893**	**-8**
Aged	63,023,814	59,261,657	-6.0	1,403	1,214	-13
Disabled and Blind	131,265,852	144,589,011	10.0	3,225	3,192	-5
Children	27,389,943	27,297,928	-0.7	594	487	-13
DDD/CCW**—Total	**$ 18,093,275**	**$ 26,912,562**	**49.0**	**1,998**	**2,928**	**26**
Aged	646,914	908,982	41.0	59	92	31
Disabled and Blind	16,229,568	24,309,043	50.0	1,608	2,389	31
Children	1,216,793	1,694,537	39.0	331	447	2
OTHER CATEGORIES	**$ 320,745,996**	**$ 337,896,898**	**6.0**			**-1**

*Payments exclude off-system adjustments. Excludes $278,787 HMO Capitation payments in 1984 and $428,669 in 1985. Excludes $8,452 MP Plan payments in 1984 and $791,539 in 1985.
**DDD/CCW—Division of Developmentally Disabled/Community Care Waiver; SRS—Special Residential Services.

Source: *Medicaid, Fiscal Year 1986. Annual Report,* State of New Jersey, Department of Human Services; Division of Medical Assistance and Health Services.

TABLE III-5

GENERAL FUND EXPENDITURES FOR SENIOR CITIZENS AND DISABLED; PERSON PROPERTY TAX REDUCTION AND PAAD PROGRAMS

(IN MILLIONS)

EXPENDITURES	1978-79	1979-80	1980-81	1981-82	1982-83	1983-84	Revised Estimate 1984-85	1985-86
PAAD	33.86	36.29	39.60	44.1	42.8	43.6	49.1	50.3
(June elegibles)	280,938	280,514	259,295	232,518	201,000	197,000	177,000	159,000
Property Tax Reduct.	30.3	29.3	28.2	27.6	15.8	14.5	13.8	27.9

CASINO REVENUE FUND—EXPENDITURES

(IN MILLIONS)

	1978-79	1979-80	1980-81	1981-82	1982-83	1983-84	1984-85	1985-86
REVENUES	18.3	58.1	72.0	103.4	130.6	152.8	167.00	176.00
EXPENDITURES								
Homestead Rebates	11.0	17.0	17.0	80.4	19.4	20.5	20.2	0
PAAD	0	0	0	1.5	19.4	25.5	27.7	39.8
Lifeline Credit Programs	0	21.0	26.9	41.1	51.6	58.9	67.5	75.0
Property Tax Reduct.	0	0	0	7.3	25.8	30.4	30.4	17.9
Community Care	0	0	0	0	0	0.17	5.0	17.6
Personal Care (Waiver)								
Transportation Act	0	0	0	0	0	3.0	10.0	11.5
Congregate Housing	0	0	0	0	0	0.55	0.62	0.7
Boarding Home Rental	0	0	0	0	0	0.75	1.0	5.3
Medically Needy	0	0	0	0	0	0	0	8.4
Various Health Programs								
TOTAL	**11.0**	**38.0**	**43.9**	**130.8**	**116.3**	**139.9**	**162.6**	**176.5**

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(Compiled by John P. Tergis).

transportation services. Since the passage of these two constitutional amendments, the number of programs funded from casino revenues has increased through accretion. Several programs funded by casino revenue are operated by departments of New Jersey Government, with some of the casino funded programs having Federally-matching monies. The program areas funded from casino revenue include: utility and property tax relief benefits, health care benefits and services, transportation services, home-care services, and food benefits.

The two largest programs are the *Lifeline Credit—Tenants Assistance Programs* (totaled approximately $63 million for fiscal year 1987) and the *Pharmaceutical Assistance to the Aged and Disabled Program* ($41 million for fiscal year 1987) (See Table III-6). The *Lifeline Credit Program* provides a $225 annual credit for combined gas and electric utility expenses. The program applies to both tenants and homeowners. Lifeline, as of 1988, has eligibility requirements of $13,650 for the single elderly and $16,750 for a married couple. Current estimates reveal over 300,000 households eligible for the program. *Pharmaceutical Assistance to the Aged and Disabled* incurs the costs of prescription drugs after a participant's co-payment of two dollars.

TABLE III-6

PHARMACEUTICAL ASSISTANCE FOR THE AGED AND DISABLED AND LIFELINE CREDIT PROGRAMS

(Expanded Eligibility Requirements, Funded from the Casino Revenue Fund)

	Actual FY 1987	Revised FY 1988	Budget Estimate FY 1989
Aged			
Average monthly recipients	80,347	92,043	95,161
Annual prescriptions	1,647,263	2,098,580	2,226,767
State cost per prescription	$18.21	$19.57	$21.59
Annual State cost—Casino Revenue Fund (thousands)	$29,997	$41,069	$48,076
Disabled			
Average monthly recipients	18,853	18,741	15,662
Annual State Cost—Casino Revenue Fund (thousands)	$11,068	$13,825	$13,778
Lifeline Programs:			
Lifeline Credit			
Recipients	173,950	173,575	175,475
Annual State Cost (thousands)	$39,139	$39,054	$39,482
Tenants Assistance			
Recipients	105,575	107,800	110,650
Annual State Cost (thousands)	$23,754	$24,255	$24,896

Source: *New Jersey Annual Budget FY 1988-89.*

Data indicate that over 40 percent of PAAD recipients are in the age bracket 65-75, with 38 percent in the 76-85 bracket. Counties, such as Bergen, Essex, and Hudson, each have over 20,000 senior citizens eligible for the *Pharmaceutical Assistance to the Aged and Disabled* (Table III-7). Eligibility requirements are the same as for *Lifeline*, with about 255,000 New Jersey residents presently served by the program. Data on the *Lifeline Program* show that Hudson and Essex Counties have over 30,000 participating households; and Bergen, Passaic, and Camden Counties have over 20,000 participating households. The Fund pays for elderly making over set income levels, with the poor's prescription drug expenses financed out of general revenue.

The Casino Revenue Fund also pays elderly residents a $250 property tax deduction ($17.9 million), and $5.3 million for elderly-based boarding homes that require life safety improvements. Two of the most important programs funded through casino-raised revenue are *congregate housing support services* ($.7 million), which provides meals, housekeeping and personal care for eligible residents of 21 senior citizen housing developments in the State (See Table III-5), and the *meals on wheels grant program* ($1 million), which augments the Title III weekday home-delivered meal program with delivered meals on weekends and holidays.

Several new or about to be adopted programs have been developed which are based or are partially reliant on Casino Revenue Fund expenditures. These programs constitute expanded assistance for the State's elderly in three main areas: personal home care, transportation assistance, and protective services. Two of these newly-adopted programs, *Senior Citizen Housing—Safe Housing and Transportation* ($3 million) and *Community Care* ($20.5 million) provide partial funding in an attempt to stabilize the existing housing arrangements of the elderly. *Senior Citizen Housing* is targeted for congregate housing arrangements, with funding targeted at providing shuttle services for clothing and food shopping, and increasing security at congregate housing sites.

In contrast, the *Community Care Program's* goal is to enable New Jersey senior citizens to remain in their homes. This is done by providing long-term care in the home. Services included within the program are home health care, required transportation, medical care, homemaker service and case management. This program, which is seen as a cost-effective alternative to long-term institutional care, is available to those who are Medicaid non-eligible but still in need.

In addition, a new array of medical services has been established which extend the health care coverage of senior citizens. Included within this category are: *Personal Care Assistant Services* ($2.3 million), *Medicaid Expansion—SOBRA* ($28.1 million) and the *Alzheimer's Disease Demonstration Day Care Center Program* ($1.1 million), and *Hearing Aid Assistance for the Elderly and Disabled* ($1.5 million). *Personal Care* provides health-related services, which are given to patients eligible for institutionalization who can, with these services, remain in their homes. *Medicaid Expansion-SOBRA* raises the income level of those eligible for Medicaid coverage to the Federal poverty level. Legislation passed by Congress in 1986 changed the Medicaid eligibility criteria. Prior to this Federal law, many elderly and disabled persons were ineligible for Medicaid coverage even though their incomes were signifi-

TABLE III-7

PHARAMACEUTICAL ASSISTANCE TO THE AGED AND DISABLED (PAAD) BY COUNTY

County	Number Persons			Amount Paid		Average Payment Per		Average Cost Per Claim	
	Disabled	Aged	Total	Disabled	Aged	Disabled Recipients	Aged Recipients	FY 1986	FY 1987
Atlantic	630	8,545	9,175	$ 366,597	$ 3,489,908	$582	$408	$16.51	$18.25
Bergen	1,538	21,893	23,431	958,450	8,134,842	623	372	15.91	17.66
Burlington	663	8,127	8,790	438,987	3,228,028	662	397	15.90	17.66
Camden	1,533	15,734	17,267	955,064	6,589,680	623	419	16.63	18.38
Cape May	275	4,853	5,128	135,652	2,045,045	493	421	16.86	18.67
Cumberland	708	5,225	5,933	385,818	2,009,900	545	385	16.28	17.69
Essex	2,589	22,295	24,884	1,408,446	8,539,966	544	383	16.32	18.25
Gloucester	647	5,922	6,569	403,059	2,620,517	623	443	16.71	18.31
Hudson	1,872	18,554	20,426	1,042,668	7,082,212	557	382	15.44	17.23
Hunterdon	144	1,799	1,943	75,858	742,264	527	413	16.99	18.65
Mercer	853	9,985	10,838	505,183	3,933,014	592	394	16.65	18.42
Middlesex	1,263	14,506	15,769	751,075	5,838,688	595	403	16.72	18.73
Monmouth	1,231	13,949	15,180	707,417	5,297,712	575	380	15.85	17.71
Morris	514	6,878	7,392	280,486	2,551,797	546	371	15.66	17.18
Ocean	1,118	18,377	19,495	612,227	6,358,200	548	346	16.95	18.64
Passaic	1,359	14,663	16,022	771,378	5,652,306	568	385	15.94	17.91
Salem	209	2,040	2,249	129,572	938,013	620	460	18.16	19.91
Somerset	338	3,747	4,085	198,446	1,372,275	587	366	16.33	18.22
Sussex	219	2,789	3,008	139,178	1,091,186	636	391	16.59	18.47
Union	1,273	1,273	15,768	677,776	5,497,832	532	379	16.45	18.35
Warren	248	3,171	3,419	124,742	1,280,850	503	404	15.70	17.26
Total	**19,224**	**217,547**	**236,773**	**$11,068,079**	**$84,294,235**	**$576***	**$387***	**$16.27***	**$18.07***

Source: *PAAD 1987 Annual Report.*

*State Average

cantly below the poverty line. It is expected that more than 65,000 additional New Jersey senior citizens and disabled residents will now qualify for coverage.

Hearing Aid Assistance and *Alzheimer's Day Care* are new initiatives which extend the range of available health services. *Hearing Aid Assistance* provides up to $100 annually toward the purchase of a hearing aid; while *Alzheimer's Day Care* establishes demonstration day care centers for those with Alzheimer. The latter program is expected to benefit about 1,000 persons.

A final set of these newly formed programs under Casino Revenue Funding include: county development, under the auspices of the New Jersey Transit Corporation, of access and local transportation services for senior citizens and the disabled; a county system for protecting the elderly against abuse by establishing supportive services for those abused; a waiver system from various Federal Medicaid regulations for services which can be provided more cost-effectively at home; and respite care for individuals providing care for the elderly in their homes.[8]

SUMMARY

New Jersey Government has long been active in promoting the welfare of its senior citizens. It was the first state in the nation to establish a state government office of elderly affairs, doing so in 1957. With its establishment of casino gambling in Atlantic City in 1976, the State established the collection of revenue from casino profits to be used exclusively to aid the State's elderly and disabled. In addition, large numbers of elderly residents are assisted by New Jersey's Human Services programs.

The State Division on Aging has central responsibility for overseeing the programs of the national Older Americans Act. Major programs within the Act include nutritional services, transportation services, and in-home services for the frail elderly. The Division on Aging also has central responsibility for coordinating intergovernmental efforts among the national Administration on Aging, other State departments and agencies, and County Offices on Aging. It also serves as a conduit for Older Americans Act funding of programs for the elderly that are operated by County Offices on Aging.

Of the State Human Services programs, Medicaid is by far the largest, serving more than 500,000 individuals and involving more than one billion dollars in expenditures. Of this total amount, over a third was expended on nursing home care, with the overwhelming majority of recipients being senior citizens. Medicaid has recently been expanding its efforts in underwriting *home support* services.

Programs underwritten by the Casino Revenue Fund also plays an important role in aiding senior citizens. Casino Revenue Fund expenditures

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[8]*State of New Jersey,* The Casino Revenue Fund Study Commission (New Jersey State Government: December 1985), and *The New Jersey Budget Message and Taxpayers' Guide 1987-88* Governor Thomas H. Kean (New Jersey State Government: 1987), Chapter VI, pp. 25-29.

currently total $250 million a year. The two major programs, funded from casino revenues, are *Assistance for Pharmaceutical Expenses* and the *Lifeline Credit—Tenants Assistance Programs* which provide a $225 annual credit for combined gas and electric utility expenses. There are over 220,000 elderly recipients for the *Pharmaceutical Assistance Program.* Presently, the *Lifeline Programs* have over 173,000 recipients.

The Casino Revenue Fund also pays elderly residents a $250 property tax deduction. The past few years have witnessed expansion of casino revenue funding into congregate housing support services, personal and health home care, transportation assistance, and protective services. Current total State expenditures for the elderly come close to $700 million a year.

CHAPTER IV
COUNTY OFFICES ON AGING

INTERGOVERNMENTAL CONTEXT FOR COUNTY OFFICE ON AGING'S ROLE

Over the past 20 years New Jersey has witnessed both a burgeoning in the numbers of elderly and in the range of available senior citizen services. Concomitantly, this growth has spurred the development of an administrative system responsible for overseeing the newly instituted programs. Regarding servicing the elderly, the locus of governmental action resides at the county level. County government is close enough to its elderly population to address its specific needs yet large enough to administer large-scale programs efficiently.

What has emerged, county-wise, is an array of senior citizen programs that have developed along different tracks. Some programs have emerged as the result of county government initiative, while others have resulted through the joint endeavor of county, State, and Federal governments. It is the latter effort which has been the most vital in establishing an integrated set of services that meet the needs of the elderly population and give some cohesion to administrative arrangements that are overall fragmented. The pivotal role, within this intergovernmental network, is played by the *County Office on Aging.*

ADMINISTRATIVE ORIGINS OF THE COUNTY OFFICE ON AGING

Within the intergovernmental aging network, the *County Offices on Aging* serves as the point of contact between government and the State's senior citizens. The *County Offices on Aging's* establishment is the result of the cross-fertilization of State and county government concern with elderly issues and the fiscal incentives and program initiatives of the Older Americans Act at the Federal level. The 1973 Amendments to the Older Americans Act sought to encourage State and regional action to improve the planning and provision of elderly services for *Title III* programs (*Access Services, In-Home Services, Community and Neighborhood Services*). Specifically, state agencies on aging were encouraged to divide their state into geographic regions and within each region establish an *area agency on aging.* Each of these regions constitutes a planning and service area, with the *area agency* responsible for developing the area's social service delivery system for the elderly.

The formation of an *area agency on aging* entitles that body to receive and distribute Older Americans Act *Title III* funds. Each *County Office on Aging* was designated the *area agency on aging* by the State of New Jersey in order to meet the Federal eligibility requirement for Older Americans Act funds. Designation as an *area agency on aging* gives the County Office dual responsibilities: in its role as a *County Office on Aging,* county functions are

performed, but the office is also beholden to State and Federal requirements which emanate from the Older Americans Act.

With the passage of State enabling legislation and pursuant county freeholders' actions, a *County Office on Aging* was established for each of the 21 county governments. Acting as a middleman between the Federal Government and each of the *County Offices on Aging* is the State Division on Aging. The Division distributes Federal *Title III* funds on a formula basis to each *County Office on Aging*, with the *County Office on Aging* utilizing these funds to develop and administer an *area plan on aging* whose overarching goal is the development of a comprehensive and coordinated system of services for each county's elderly population.

Receipt of this funding is contingent upon the area plans of the county offices being approved. Such approval ensures the *area agency* of funding upwards to 85 percent of the costs for supportive services, senior centers' operations and nutrition programs. *County Offices on Aging* usually contract out to nonprofit organizations to provide the services specified in the area plan. Each of the designated institutions on elderly affairs—the Administration on Aging at the national level, the Division on Aging for New Jersey, and the *County Offices on Aging*—is responsible for advocacy and coordination within its sphere of geographical responsibility. Primary attention is focused on those elderly of greatest need.

In developing a statewide network, the rationale for the selection of the *County Offices on Aging* as the link between the State Division on Aging and the local elderly citizenry is based on several critical considerations. Chief among these are the county's institutional stability and administrative and fiscal experience. As an ongoing body of government, counties have:

- Major responsibility for maintaining the well-being of a diverse population;
- Extensive experience in administering different human and community service type programs in both well populated and rural settings;
- Ongoing involvement in providing State Government sponsored services to their population; and
- The structural continuity and stable financial base to ensure trustworthiness in administering a set of social programs and their financing.

As the implementing offices of the State aging network, the *County Offices on Aging* are primarily responsible for developing and operating comprehensive, coordinated systems of community-based services. In conjunction with New Jersey's Division on Aging, which exercises oversight responsibilities, the *County Offices on Aging* administer Federal Government *Title III* funds and monitor and evaluate all *Title III* funded projects within their county.

In addition, the *County Offices on Aging* exercise several other important responsibilities, which are consistent with the general purpose of the Older

Americans Act. Among the major duties undertaken by County Offices are:

- The coordination of all programs on aging irrespective of funding sources;
- Serving as the administrative locus for information and referral on existing senior citizen services;
- Design of the *area plan on aging*, which constitutes an inventory of existing resources, and the development of a comprehensive plan for delivering services to the elderly; and
- Serving as the advocate and representative of the elderly before all institutions engaged in actions affecting the elderly within the county.

The establishment of the Bergen County Office on Aging in 1966, the first County Office in the nation, marked the initial step in New Jersey's development of a statewide aging network. The completion of this institutional network established counties as the administrative nucleus in implementing State, Federal and county elderly programs. In addition to the State and Federal programs, which have provided uniformity and consistency in servicing the elderly, county governments have played an important role by serving as a testing ground for introducing new services for the elderly. New Jersey counties' *Offices on Aging* often hold responsibility for demonstration projects within their counties. Also, the *County Offices on Aging*, in conjunction with their respective county governments, have developed individual programs to fulfill specific county-oriented unmet needs of their elderly residents.[1]

Each of the *County Offices on Aging* oversees a range of services, with all sharing in common responsibilities to achieve Federal and State defined goals. Also, counties, in operating different elderly services established by county government, play an important innovative role in broadening the scope of services for the elderly and restructuring existing senior citizen programs. Thus, counties both share a common set of elderly programs and have their own individual county senior citizen programs which are targeted at the specific needs of their county's elderly.

The main administrative role performed by the *County Offices on Aging* is that of overseer of services rather than that of direct provider of services. ***Monies provided to the County Offices are, in most cases, used to contract for services with nonprofit organizations.*** In some instances where no suitable nonprofit organization exists, or to increase efficiency, *County Aging Offices* directly provide the services themselves. Slightly less common are situations in which another agency of county government, a proprietary or-

[1]The above section is based on The Divison on Aging, *New Jersey State Plan on Aging under Title III of the Older Americans Act of 1965*, (Trenton: State of New Jersey, Department of Community Affairs, 1986) and The Division on Aging, *New Jersey Department of Community Affairs Division on Aging: History ... Functions ... Organization* (Trenton: State of New Jersey, Department of Community Affairs, 1986).

TABLE IV-1

FEDERAL AND STATE AID TO COUNTY OFFICES ON AGING (1987)

	Supportive Services	Congregate Meals	Home Delivered Meals	Federal Aid Total	State Aid 5 Percent Match	Grand Total
Atlantic	$ 308,797	$ 408,726	$ 86,585	$ 804,108	$ 43,280	$ 847,388
Bergen	873,615	1,155,076	244,692	2,273,383	122,362	2,395,745
Burlington	256,019	338,850	71,782	666,651	35,882	702,533
Camden	478,808	633,060	134,108	1,245,976	67,063	1,313,039
Cape May	150,000	182,451	38,651	371,102	19,974	391,076
Cumberland	150,000	201,861	42,762	394,623	21,240	415,863
Essex	1,138,556	1,506,185	319,071	2,963,812	159,523	3,123,335
Gloucester	172,984	228,726	48,453	450,163	24,229	474,392
Hudson	786,791	1,040,456	220,409	2,047,656	110,212	2,157,868
Hunterdon	150,000	130,000	30,000	310,000	16,685	326,685
Mercer	337,866	446,728	94,636	879,230	47,323	926,553
Middlesex	477,545	631,322	133,738	1,242,605	66,881	1,309,486
Monmouth	527,054	697,213	147,697	1,371,964	73,844	1,445,808
Morris	289,025	382,369	81,001	752,395	40,497	792,892
Ocean	529,878	700,176	148,325	1,378,379	74,189	1,452,568
Passaic	494,493	653,796	138,500	1,286,789	69,260	1,356,049
Salem	150,000	130,000	30,000	310,000	16,685	326,685
Somerset	159,082	210,441	44,580	414,103	22,289	436,392
Sussex	150,000	130,000	30,000	310,000	16,685	326,685
Union	603,251	798,144	169,079	1,570,474	84,528	1,655,002
Warren	150,000	130,000	30,000	310,000	16,685	326,685
TOTAL	**$8,333,764**	**$10,735,580**	**$2,284,069**	**$21,353,413**	**$1,149,316**	**$22,502,729**

Source: *Summary of Title III Program Systems Tracking Report for 1987,* New Jersey Division on Aging.

ganization, or a municipality operates the program. In contracting out services, with others involved with service-delivery, the *County Offices* incur responsibility for ensuring the financial accountability of the actual providers.

On behalf of their efforts, the *County Offices* receive direct support from the State Division on Aging. This support includes technical and financial assistance. The Division financially underwrites a good share of the monies necessary for *County Offices'* administrative operations. Furthermore, the Division provides continuous training for *County Office* staff.

Regarding funding, formula monies are forthcoming from the Federal Government's *Title III* Program, others are provided from State earmarked funding, a certain percentage of which consists of matching State funds. The *Title III* Federal and State expenditures for 1987 came to over $22 million of which about $13 million was spent on meals for the elderly and about eight million dollars for *supportive services* (Table IV-1). Local funding for *Title III*, of which the overwhelming share was county monies, came to over nine million dollars in 1987. As was noted previously, county freeholders in many cases also provide additional funding for elderly programs and *County Offices* also receive grant monies. Other sources of *County Office on Aging* funding include private contributions and client fees for designated services.

The overall fiscal pattern is one of a sizeable, stable funding base from Federal, State, and county sources. County governments, for the most part, have routinized their underwriting of particular programs. In addition, the intermittent receipt of monies from Federal block and categorical grants, and private contributions allows *County Offices on Aging* occasionally to expand the range of services and experiment with new programs.

PROGRAM RESPONSIBILITIES OF THE COUNTY OFFICE ON AGING

The multitude of services provided by the *County Offices on Aging* can be identified in terms of four major categories: 1) *Access Services* 2) *Nutrition Services* 3) *Home Support Services* and 4) *Community Support Services.* Total *support services* reached over 805,000 senior citizens in 1987, of which over 105,000 were low-income and about 40,000 were minority persons (Table IV-2). The general purpose of these programs is to sustain the well-being of

TABLE IV-2

N.J. SUPPORTIVE SERVICE RECIPIENTS FY 1987

Total Number of Elderly Recipients	805,266
Older Persons With Greatest Social Need	40,037
Older Persons With Greatest Economic Need	105,455
Minority Recipients	40,037

Source: *Program Performance Report for Title III of the Older Americans Act, for State of New Jersey, Fiscal Year 1987* (Washington, D.C.: U.S. Department of Health and Human Services, Administration on Aging, 1987).

New Jersey senior citizens and to aid them in maintaining independent lifestyles. This latter objective entails helping senior citizens remain in their place of residence, thus avoiding unnecessary institutionalization.

Access Services

An important function performed by the *County Offices on Aging* is that of offering *access services.* The *County Office's* "access" role entails identifying eligible senior citizens, informing them of available services, placing them in contact with the provider and assisting them in insuring that the service is received. Regarding these objectives, the *County Office* serves as the link between the elderly who are eligible and in need of certain services and the providers of these services. Its responsibility of linking the elderly with the provider also extends to transporting the elderly from community facilities to places where the provider furnishes the service. Over 300,000 New Jersey senior citizens received *access services* in 1987 (Table IV-3).

In following through from referral to the provision of the service, the *County Office* maintains comprehensive records and data on its "access role" so that the depth of contact with the county's elderly population can be gauged. The scope of administrative oversight in insuring the elderly's receipt of services has expanded to the *County Offices'* undertaking "case manage-

TABLE IV-3
PROVISION OF SUPPORTIVE SERVICES, FY 1987

ACCESS SERVICES	NUMBER OF RECIPIENTS
Information/Referral Services	309,585
Transportation Services	76,516
Outreach Services	39,897
COMMUNITY SERVICES	
Health Services	33,622
Legal Services	9,540
Residential Repair/Renovation Services	1,585
All Other	320,090
IN-HOME SERVICES	
Visiting/Telephone Reassurance Services	5,985
Homemaker Services	1,279
Home Health Aid Services	1,835
Chore Maintenance Services	638
All Other Services (Respite Care, Hospice Care, Visiting Nurse)	1,767

Source: *Program Performance Report for Title III of the Older Americans Act, for State of New Jersey, Fiscal Year 1987* (Washington, D.C.: U.S. Department of Health and Human Services, Administration on Aging, 1987).

ment" for the frail or functionally-impaired elderly. Its "case management" responsibilities encompass the development of individualized programs of care for the frail and functionally-impaired elderly individual, the coordination, authorization and arranged payment for these services, the monitoring of the services provided, and the periodic assessment of the care plan to determine if continuation of the present package of services is warranted or if some alterations are necessary.

Nutrition Services

Another basic set of services for senior citizens consists of nutrition programs. For those who are incapacitated in some way and/or economically needy, these constitute some of the most vital services. Two programs, providing prepared meals for the elderly, are in operation: a home delivered meal program and meals for the elderly at group sites.

- **Home Delivered Nutrition Program**—The home delivered meal program is designed to provide at least one hot meal daily, a minimum of five days a week. Over 18,000 elderly, of which close to 7,000 are low-income and over 2,000 are minority persons, are presently served by this program. Close to two million home delivered meals are provided a year (Table IV-4). Eligibility

TABLE IV-4

CONGREGATE AND HOME-DELIVERED MEALS
FY 1987

CONGREGATE MEALS	
Total Number Congregate Meal Sites	279
Number Sites in Areas With High Concentration of Low-Income Elderly	120
Total Number Congregate Meals Served	3,477,489
Total Number of Eligible Persons Served	43,931
Older Persons with Greatest Social Need	4,863
Older Persons with Greatest Economic Need	14,983
Minority Persons Served	4,863
HOME DELIVERED MEALS	
Total Number of Home-Delivered Meal Providers	48
Total Number of Home-Delivered Meals Served	1,950,265
Total Number of Eligible Persons Served	18,848
Older Persons with Greatest Social Need	18,848
Older Persons with Greatest Economic Need	6,823
Minority Persons Served	2,205

Source: *Program Performance Report for Title III of the Older Americans Act,* for State of New Jersey, Fiscal Year 1987 (Washington, D.C.: U.S. Department of Health and Human Services, Administration on Aging, 1987).

criteria for home delivered meals include being homebound or incapacitated, being unable to prepare meals, and lacking the friends and family to aid in the preparation of meals. Particular attention is given to covering emergency situations such as treacherous weather conditions or vehicle breakdowns.

- **Congregate Nutrition Program**—This second food program for the elderly provides meals at congregate sites a minimum of five days a week. About 44,000 eligible persons received congregate meals in 1987, in 279 sites around the State, with about 3,500,000 such meals served. About 15,000 of the recipients were low-income elderly (Table IV-4).

At least one of the daily meals must be a hot meal. The spouse of the elderly person is also eligible for congregate meals, regardless of age. The congregate nutrition program usually has a suggested voluntary donation. However, those who cannot afford or choose not to contribute to the cost of the program are not barred from the meal benefits. Food stamps are accepted as financial contributions for congregate meals.

Home Support Services[2]

A broad array of *home support services* fall under the purview of the *County Offices on Aging.* The ability of the homebound elderly to retain their home residence often requires use of community services and retaining social contact with others. Meeting these needs can entail social and physical support. Toward this end, several services are available. In noting the various programs that exist to ameliorate the home situations of New Jersey's elderly, we shall discuss them in terms of different categories of support. Each category represents a different facet of needed support for the elderly.

- **Escort Services** are available for the homebound elderly who need personal help in going to stores, banks, medical offices, and supermarkets. A designated individual provides transportation or runs errands for a functionally-impaired elderly person. Such services, which solely entail the provision of essential errands, are performed for the homebound when no family member or close neighbor is available to render these services.

- **Friendly Visiting**—This program furnishes social support for senior citizens living in isolation. Companionship and the opportunity for social interaction are provided for the elderly person without close friends and relatives. The staff make social calls and assist their elderly clients with basic tasks such as household budgeting, reading, and letter writing.

- Serving a similar function to that of *friendly visiting,* albeit a more distant role, is that of **Telephone Reassurance.** Here a service is organized to telephone the homebound elderly on an ongoing basis. Such calls offer

[2]Major portions of the information in the following three sections (*Home Support Services, Community Support Services,* and *Nutrition Support Services*) were obtained from the Division On Aging, *Service Taxonomy* (Trenton: New Jersey State Government, 1987) and the Division On Aging, *Statewide Benefits For Older Persons* (Trenton: New Jersey State Government, 1987).

social contact and psychological reassurance for the homebound elderly who live alone. In addition the program seeks to ascertain the well-being and safety of the homebound elderly on a continuous basis. One underlying purpose of the program is to monitor the elderly person's changing condition.

Personal Support

Another fundamental *home support* category is that of ***Personal Support.*** The goal of these programs is to enable the incapacitated elderly to maintain themselves in their place of residence by providing health and other personal services. ***Personal Support*** is provided through a network of proprietary, non-profit and county/municipal organizations.

Some of these services are funded through *Title III* monies, given to the *County Offices on Aging,* which contract out the services to the above mentioned organizations. Others come from Federal Social Service Block Grants, with the county *Human Services Advisory Councils* parceling off some of the funding for *home-care.* There are other sources of funding as well.

• A major program within *personal support* is that of ***Homemaker/Home Health Aide,*** also commonly referred to as *home-care.* The service focus here is on personal grooming and performance of minor household tasks. Daily personal assistance chores include feeding, bathing, grooming, attention to personal hygiene, dressing, exercising, ambulatory aid, and assisting with self-administered medication. Also included are performance of light household duties related to health maintenance, such as cleaning the bathroom after a client's bath, cleaning the kitchen after meals, bed linen changes and laundering. Homemakers also provide light housekeeping duties such as sweeping, dusting, ironing and mending of clothes. Essential errands are also provided such as grocery shopping, purchasing medication, and transporting or accompanying the client to obtain items and services that are basic necessities, such as going to the bank, physician's office, and supermarket. Eligibility for the *homemaker/home health aide* program is limited to those in need who do not quality for any similar kind of program.

The providers of these services include non-profit, proprietary, and county/municipal agencies. The vast majority of homemaker organizational providers are for profit, with roughly 200 such firms serving about 100,000 elderly per year, compared to 22 non-profit home care agencies serving about 24,000 people. Figures for 1985 indicate that about 3,500 New Jersey senior citizens received *home-care* from Social Service Block Grant funding.* The county governments of Mercer, Middlesex and Camden directly provide some home-care services.

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*Numbers of elderly programs are partially funded by Social Service Block Grant monies from the Federal Government. Service categories include: *adult day care, home-delivered meals,* and *homemaker services.* Projections for fiscal year 1989 are for three million in Social Service Block Grant monies to consist of contracts with County Offices on Aging for services, $1.7 million of which passes through county welfare agencies to County Offices on Aging. Source: *Social Services Block Grant Fiscal Year 1989, Pre-Expenditure Report,* New Jersey Department of Human Services, Office of the Associate Commissioner for Policy and Intergovernmental Affairs, 1988.

New Jersey's Department of Health presently licenses 55 home-health agencies, of which the overwhelming majority are non-profit. The basic services provided by these licensed home-health agencies include skilled-nursing, physical-therapy, homemaker-home health aide, medical and social work, speech and occupational therapies and nutrition services. Private payment, whether personal or private insurance, provides only about eight percent of home health care costs. The Veterans Administration, through the Veterans Medical Center in East Orange, operates a home-health care program which provides over 4,500 in-home health care visits to about 140 veterans.

Residential Upkeep Programs

Complementing *personal support* are the ***Residential Upkeep*** programs. For those with chronic health problems, in addition to the medical attention and aid with light household duties associated with personal well-being, there is a need also for help with the ongoing requirements of *residential upkeep.* These entail performing physically vigorous tasks such as home repairs, seasonal house maintenance, housekeeping, and home protection.

For the majority of New Jersey's population, the above noted functions go part and parcel with homeownership, and thus are not thought about particularly. But for the elderly, physically limited by severe chronic illness, financial and physical hardship often makes attendance to these basic home maintenance chores impossible. Without assistance, the elderly would not be able to maintain themselves at home and, thus, in all likelihood, would be driven into institutional care.

Two programs exist within the State of New Jersey that constitute resident upkeep assistance: *residential maintenance* and *housekeeping.*

- **Residential Maintenance** entails the performance of physically exertive tasks on behalf of senior citizens who are at risk in attending to such activities and lack the family member or neighbor to assist in these chores. Included within this program are chores such as snow removal, yard and walk care, cleaning attics, basements, and garages, making minor home repairs such as weatherization and replacing door locks, and doing plumbing, electrical work, roofing and other similar kinds of tasks that prevent home deterioration. The purpose of *residential maintenance,* it should be emphasized, is support of the person's health and safety to enable them to remain in their homes, rather than esthetic improvements.

- A second ***Residential Upkeep*** program, that of ***Housekeeping,*** is designed to provide housecleaning services as a means of enabling senior citizens to maintain their place of residence. Eligibility criteria include the absence of family or neighbors that can provide such services. Similar to *residential maintenance,* the purpose of this program is to assist the elderly, who have physical problems, so that they can remain within their home. Tasks performed under *housekeeping* include preparation of meals, laundry service, dusting, mending, cleaning, and washing of floors.

Relief for the Care-Giver

A fourth category of support services places emphasis on the caregiver. The underlying idea behind these programs is that relief is necessary for the

caregiver, otherwise the voluntary system of assistance to loved ones can break down, followed by the necessity of major governmental involvement and possible institutionalization of the tended-to individual. Relief assistance programs for caregivers include: *respite care* and *caregiver support groups.*

- **Respite Care** provides intermittent relief for caregivers who are looking after an elderly person on a continuous basis. Though the program is operated by the State's Department of Human Resources, *Aging Offices* are often involved in referrals. The duration of respite care services varies from a couple of hours on a given day of the week to a weekend of care. Priority for respite care is given to those aiding elderly who are eligible for placement in an intermediate care facility if they were not receiving proper attention. Preference is also given to those individuals who are most socially and economically disadvantaged. *Respite care* services include personal care, food preparation, companionship, and aid with daily activities.

- A second relief program is the **Caregiver Support Group.** This program is designed to provide social and psychological aid to the caregiver experiencing stress in providing care. In general, caregivers of those with Alzheimer's disease, those suffering strokes, and terminally-ill patients, experience extreme psychological tension. The *County Office* is one of several agencies administering this program for the Gerontology Program within New Jersey's Department of Health. The *County Office on Aging* organizes the caregiver support group, and informs caregivers who may have a need for this service. In addition to its use in alleviating stress, the support group also provides information about additional programs and services for which caregivers may be eligible.

Ancillary to the *caregiver support group* is the **Family Care-Giver Education Project**[3] administered by the *County Offices on Aging* and other institutions in the State. Also operated by the State Department of Health's Gerontology Program, the program essentially provides informational sessions within the community setting for those individuals involved in care-giving within the home. Twelve hourly courses, which impart practical information to care-givers, are provided. In it, attendees are informed about public benefits that are available for the homebound elderly and their caregivers, the eligibility criteria, alternate housing possibilities, and the special needs of the homebound elderly. Given the difficulty many working people face in finding the time to attend such sessions, numbers of these courses have been held in corporate settings. There is some encouragement being given to have corporations set up adult day care programs similar to the child care programs established in the previous couple of decades, or possibly establish adult day care as one of the optional benefits within an employee's package of health coverage.

[3]The information on the *Family Care-Giver Education Project* is based on an interview with Rick Greene, Coordinator of the Gerontology Program, N.J. Department of Health, and Department of Health literature on the program.

Community Support Services

In addition to *home support services* and *access services*, a third general category of programs for senior citizens exists—***Community Support Services.*** A broad array of services are subsumed within this class, all sharing in common the broadly-defined goal of aiding senior citizens by providing services within the community that enable the elderly person to maintain themselves in their place of residence. In some cases the services provided fulfill critical needs that if left unattended could force the individual into an institution. In most cases, however, the services enhance the quality of life of the senior citizen. The services encompassed within this category are: *protective services, legal assistance* and the *ombudsman programs, physical health, mental health, education, socialization/recreation,* and *language translation* and *interpretation.*

- **Protective Services** constitute a short-term intervention precipitated by an elderly person's immediate or impending difficulties. *County Office on Aging* intervention is forthcoming to protect senior citizens from neglect, exploitation, or abuse. In some counties the county board of social services also perform this task. The focus of the program is on those senior citizens who are in institutions, or homebound and isolated. The service involves cooperative efforts with other agencies that have responsibility for providing the client various needed services.

Threats to the elderly person's well-being make available to them any of several services. These include: investigation of the abuse or neglect; arrangement for the client's medical or mental health assessment; procurement of any other necessary services—such as *homemaker, meals on wheels,* or *legal services;* arrangement for providing client and/or family counseling; if the client consents—arrangement for alternate care; and arrangement for guardianship if necessary.

Legal Assistance for Senior Citizens

Within the *community-support* services, two programs exist that provide legal and legal-type aid to senior citizens. One, the **Legal Assistance** program, provides legal counseling for the elderly at community sites, and if necessary, for institutionalized and homebound individuals. Legal representation and preparation of legal documents for administrative hearings and the courts are two of the more important services provided. Problems addressed by the *legal assistance* program include: eligibility for service and financial benefits, health care, housing, probate matters, discrimination, and protective services. In addition, clients are provided with information about various programs and services for which they may be eligible.

The second legally-oriented service, the **Ombudsman Program,** is more focused, specializing in insuring proper care. Here, the ombudsman—the government's representative for clients with a legitimate grievance against a public agency and bureaucracy, can intercede on behalf of the elderly person and family representatives. Challenge may be initiated against a facility owner, an employee, or agent who threatens the health, safety, or rights of the elderly resident within a facility. The ombudsman represents the elderly resident

before the management of a facility and such social and regulatory agencies which may have authority in such matters.

Social Integration Into the Community

The fourth and final set of *community-based services* seeks to facilitate the senior citizen's social involvement within the community. In advancement of this end, several programs are in operation. Some of these programs serve to ameliorate the economic condition of elderly residents, thus making it easier for them to remain in their place of residence.

- The senior citizen **Education Program** sponsors classes designed to provide personal enrichment and practical information. The classes, which are held in public schools, colleges, senior centers and other institutional settings, include subject matter such as personal health, consumer decision-making, retirement planning, music, art, literature, and personal finances. Coordination is encouraged with established educational centers so as to minimize duplication of existing courses and most efficiently utilize available resources.

- **Socialization/Recreation Programs**—These programs, which usually operate out of local senior citizen centers, provide highly structured recreational activities. They are designed to give elderly persons a sense of community and improve the quality of their personal lives by encouraging social contact and reducing isolation. The elderly play a central role in determining the kinds of programs and activities that are offered. The range of activities include class instruction, arts and crafts projects, travel, physical activities, group tours, and sports and games. A schedule of upcoming events is set and the information distributed to senior citizens. If necessary, transportation is provided for the scheduled activities.

- **Language Translation Program**—The third program that facilitates social integration of the elderly person into the community is the **Language Translation** program. Under it, translation services are provided for those whose primary language is not English, or those with hearing or other kinds of functional impairments. The service may be either provided directly or purchased from another organization. The nature of the service extends from translation services, for those with limited English skills, to information about eligibility for other programs and referral services.

- **Senior Health Insurance Program** (SHIP)—The objective of the program is to assist senior citizens make rational decisions on their health care coverage.[4] This includes Medicare, Medicaid, and private health insurance provision. The program, which is sponsored by the Division on Aging, recruits and trains volunteers, who then aid seniors on a one-to-one basis, without a fee. *Camden County's Office on Aging*, which is one of the counties with such a program, operates it with a Division on Aging grant of $5,000.

[4]The counties which have the *Senior Health Insurance Program* are: Camden, Mercer, Monmouth, Somerset, Union, Hunterdon, Atlantic, and Morris. The counties expected to adopt it this year are Bergen, Hudson, Essex, Passaic and Salem.

• **The Retired Senior Volunteer Program** (R.S.V.P.) is another program in operation in many counties. The purpose of the program is to provide work opportunities, that fulfill public needs, in non-profit and public agencies for senior citizen volunteers. As volunteers, senior citizens receive no remuneration. The program, not only improves the level of service for those organizations which have senior citizen volunteers, but also enables the elderly to contribute in meaningful ways to the operation of public services. As a general rule, the *County Office on Aging* provides training as well as reimbursement for travel expenses incurred.

• **Housing Placement-Homesharing Program**—Another program which is operated by several counties' *Offices on Aging* is the **Housing Placement** program. In the main, the program seeks to match renters, who seek companionship and limited rental costs, with a homeowner, who is interested in companionship and additional income. The *County Office* serves as the middleman, arranging the meetings of potentially good matches after a careful screening and interview process. Generally, successful matches undergo a trial period after which a homesharing lease is drawn up. Though small numbers of matches have been forthcoming since this program's inception, the positive impact on the lives of the recipients who participate makes this a worthwhile program. Its potential appeal is greatest among the poorer half of the elderly population and those that are widowed. Given the relative newness of this program, there is good likelihood that, once the novelty of the idea is overcome, there will be increases in the number of program participants.

• **Emergency Services**—Presently, six of the *County Offices on Aging* have this program in place.[5] The program in Gloucester County is illustrative. As much as $150 can be given to a low-income elderly person whose life situation undergoes a sudden, sharp deterioration. The money can be made available on behalf of the client to providers of fuel, food, medicine, utility services and other basic necessities. Such funding assistance is offered on a one-time basis, with over 40 county elderly residents having taken advantage of the program during the past fiscal year. Monies for the program came to $6,000. The county college operates the program for the Gloucester *County Office on Aging.*

Innovative Programs

• The different *County Offices on Aging* operate some individualized programs which are worthy of mention. Camden County's Office, for example, funds the operation of a senior citizen craft store. Here, senior citizens bring hand-made items and set their remunerative price for it upon sale. The store marks-up the item in order to cover its fixed expenses. The Camden *County Office* provides $25,000 for its craft store which is operated by the non-profit group, *Senior Citizens United Community Services.* About 500 seniors a year take part in craft projects, with the store generating $6-7,000 in revenue over the $25,000 cost.

[5]The six counties are Camden, Gloucester, Hunterdon, Mercer, Passaic and Warren.

- A program operated by *Gloucester County's Office on Aging* is the **Library Assistance** program. This program makes reading materials available to elderly persons who are far-sighted and other citizens with visual problems. Under it, a grant is given to the Gloucester County Library to be used for the purchase of large print books. These books are then distributed through out the library system of the County.

- *Gloucester County's Office on Aging,* as well as other counties' Aging Offices, operate a **Senior Citizen Discount** program. In it, participating stores offer a set discount to senior citizen customers. The cost to the County for the program, in issuing the county I.D. card, is about $300, with about 2,600 elderly persons taking advantage of the program.

- *Cumberland County's Office on Aging* operates a **Pet Outreach** project. Oriented toward senior citizens living alone, the program provides parakeets or canaries and a starter kit, free of charge. The purpose of the program is to provide companionship for the elderly living alone. Approximately 70 senior citizens have taken advantage of this program the past year.

SUMMARY

The *County Offices on Aging* play the central role regarding service provision within the intergovernmental system of elderly agencies. Each of New Jersey's 21 counties has an *Office on Aging,* handling both the Federal and State supervised Older Americans Act programs and county initiated programs for the elderly. In most instances, the *County Offices on Aging* contract out to nonprofit organizations to provide the services funded by Older Americans Act monies. In addition, the *County Offices* have responsibility for coordinating all programs on aging within their respective counties regardless of funding sources.

Four major categories of services are provided by the *County Offices on Aging*: 1) *Access Services,* 2) *Nutritional Services,* 3) *Home Support Services,* and 4) *Community Support Services.* The overall purpose of these services is to maintain the well-being of New Jersey senior citizens and to enable them to continue living in their homes. For 1987, total funding for the above four categories of programs came to $30.5 million, of which the Federal Government provided over $21 million and county governments over nine million dollars.

The largest category of expenditures was *nutritional services* with about $13 million in expenditures. This paid for approximately two million home-delivered meals for the homebound, who constituted about 19,000 elderly persons. There were also close to three and a half million congregate meals served for approximately 44,000 senior citizens. Within the *access service* category, *information and referral* had over 300,000 elderly recipients and the *transportation* program had over 76,000 recipients.

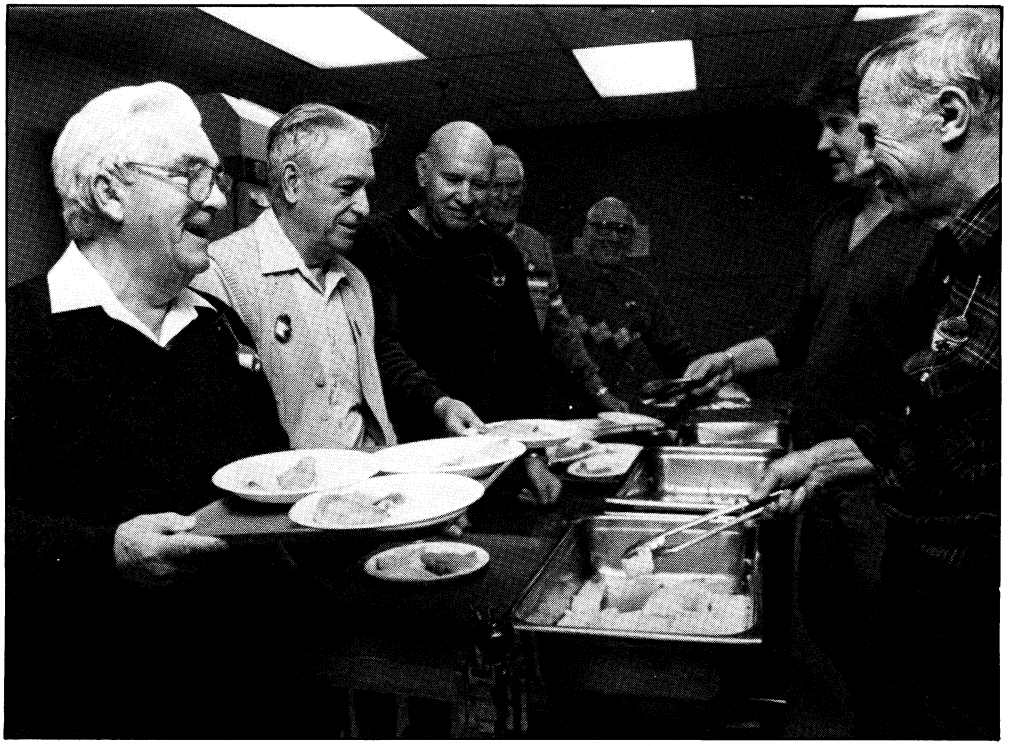
Including the rest of the programs which fall under the general rubric of *Supportive Services,* 1987 saw over 800,000 elderly receive at least one kind of *Supportive Service.* Both *community* and *home support* services are in-

tended to enable the elderly to live out as much of their remaining years as possible in their place of residence.

Regarding *community services*, programs within this category include: *adult day care, protective services, legal assistance*, both physical and mental health programs, an education program, recreational programs, and a language aid program for those lacking familiarity with the English language. The largest of these is the *physical health* program with over 33,000 clients.

The *home support* category of services include: *escort services* which entails running errands that provide essential needs for the homebound elderly; *friendly visiting* and *telephone reassurance* for the elderly living in isolation; daily assistance with personal needs such as meals, baths, grooming, dressing, ambulatory problems, medication and performance of light household chores through the *homemaker* and *home health aid* programs; home repairs and housecleaning tasks through the *residential maintenance* and *housekeeping* programs; and programs that provide relief for the care giver of the chronically-ill elderly.

Within the *home support* category, the programs with the largest numbers of clientele are: *visiting* and *telephone reassurance* programs with about 6,000 elderly recipients, the *home health aide* program with over 1,800 senior clients, and *homemaker services* with about 1,300 clients. The latter two services represent part of a broader effort to expand homecare usage for the elderly. The purpose underlying this effort involve reducing dependence on institutional care, which is highly expensive, and realizing the wishes of the elderly to remain in their own residences as long as is physically possible.




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CHAPTER V
OTHER COUNTY AND MUNICIPAL ROLES

ROLE OF OTHER COUNTY DEPARTMENTS AND AGENCIES

Within county government, a variety of agencies play a significant role in providing services for the elderly. Such responsibility takes different forms. In some cases, county offices hold sole responsibility over a particular category of senior citizen problems; in others, the particular county agency shares jurisdiction with other county offices, including the *County Office on Aging.* In addition, county departments and agencies have responsibility for various public services that include the elderly among their clients.

Furthermore, the county freeholders and various county departments fund some elderly programs which are then administered by designated county offices. In some instances, matching funds provide financing, with the agency getting specified amounts of county government monies for each dollar it receives from the State or Federal Government. Also, many programs are contracted out with the services performed by non-profit organizations.

While the lack of cohesion within the overall administrative system that provides services to the elderly may seem daunting—giving semblance to a bureaucratic maze—in reality, there is administrative integration of functions. Agencies providing similar kinds of services or complementary services coordinate efforts or, at a minimum, share information. Furthermore, given the trend toward administrative consolidation at the county level the past couple of decades, there is greater likelihood that a super-department may play a coordinating role. Also, the establishment of the County's *Office on Aging* serves to give focus to each county's provision of services to its elderly population.

In many cases, the *County Office on Aging* serves as the point of contact with elderly clients, both apprising them of services for which they are eligible and referring them to the appropriate county government service providers. People that fall between the cracks may be guided through the administrative system by the Office on Aging or some other agency with a human services role. All of these forms of interaction constitute coordination and integration of effort among the multitude of county, State, Federal and nongovernmental offices that handle elderly clients. The existence of many agencies with responsibilities toward the elderly is also an indicator of the broad array of services available for senior citizens.

Variations in the Form of County Government

We need to preface our examination by noting that structural variation exists in the forms of county governments in New Jersey and that the locus

of particular kinds of responsibilities and the nomenclature of county government organizations vary among the 21 counties. In addition, there is much intercounty variation in the degree of autonomy possessed by agencies holding different kinds of policy responsibilities.

There is a basic form of county government in New Jersey—one in which the Board of Freeholders hold combined administrative and legislative authority. In it, each separate administrative unit usually reports to a freeholder committee chairman who oversees its operation. The existence of forty or fifty separate departments is the norm in counties utilizing this form, which is the dominant form of New Jersey county government. Also, there are charter forms of county government, made possible by the 1972 passage of the *Optional County Charter Law.* While there are four different structural forms of county government possible under this plan, only two have been utilized: the "County Manager Plan" and the "County Executive Plan." Five counties have exercised the latter option which creates a chief elected official with strong administrative, appointive and budgetary powers. Optional Charter counties have all created a streamlined county administrative system with a maximum of eight super departments containing similar functions. This increases coordination among the concerned agencies.

In examining the distribution of responsibilities within the county administrative system, several distinctions are worthy of mention. There are autonomous boards, whose members are appointed by the county governing body and which have well-defined statutory responsibilities that are distinct from those of the county governing body. One such agency, whose functions we shall discuss, is the *Board of Social Services.* In addition, there is an assortment of county agencies which are directly under the control of the county governing body. These agencies report directly to the county governing body which maintains control over their policy, personnel and budgetary decisions.

County Organizational Participants

A broad assortment of services are offered by county government agencies for the elderly. They run the gamut from welfare and human services, educational offerings, recreational programs, legal counseling, nursing home care, to health care and mental health services. The costs of the individual services, per county, range from under a thousand dollars to hundreds of thousands of dollars for human service programs in the most populated counties.

• **Welfare Board/Board of Social Services**—The **Board of Social Services** determines eligibility for select Federal, State, and county welfare programs. Various categories of assistance are available to the general public, with elderly persons qualifying because they meet the income criteria, while other services are targeted for the eligible elderly. **Welfare Boards/Boards of Social Services** in charter counties, or since 1987 in noncharter counties, can be converted to a division or department of county government. In such cases, the board is placed within the county's *Department of Human Services* or

the *Department of Health and Human Services.* This has occurred in four of the charter counties.

The boards are responsible for determination of Medicaid eligibility for those elderly who qualify for *Supplementary Security Income* but choose not to avail themselves of the income support. Categories of Medicaid assistance include: in-patient hospital care, skilled nursing home services and home health care services.[1] Programs which aid the elderly, coming out of either **Welfare Boards** or **Boards of Social Services,** include: the *Food Stamp Program, Adult Protective Services,* the *Home Energy Assistance Program,* the *Homemaker Program* (some of the funding for which comes from *Peer Grouping*), the *Sheltered Care Program* (placing low-income people in the proper housing facility), *Medical Transportation* (providing transportation to medical facilities for those in an emergency situation or those without the ability to get to medical facilities), sheltering and other services for the homeless, and the *Community Care Program for the Elderly and Disabled.* The boards also perform functions such as engaging in outreach efforts and extensive case management work. Close to half of the boards perform the case management function for the *Community Care Program for the Elderly and Disabled.* In a few counties the **Board of Social Services** supervises the operation of the county nursing home.

County welfare boards have been assuming a greater case management role in placing people—the largest number of which are elderly—in boarding homes. In fact, ***most of the placement of Supplementary Security Income recipients in residential health care facilities and boarding homes is done by county welfare boards.*** The majority of counties have assumed responsibility for placing Medicaid patients, who have been declared to no longer be in need of nursing home care, in alternate places of residence.

In addition, county welfare boards have been given a major role in correcting abuse and unsafe/unsanitary conditions in boarding homes. Under the *Rooming and Boarding House Act of 1979* (P.L. 1979, c. 496; C30), county welfare boards are required to receive and investigate reports of abuse and exploitation in boarding homes. County welfare boards, in conjunction with the State Departments of Community Affairs and Health, are also required to receive and coordinate the assemblage of reports on unsafe and unsanitary conditions in boarding homes. In performance of this charge, they are required to identify eligible recipients and provide the necessary information, do need assessments, referrals, and coordination of services for boarding home and residential health care residents.[2]

• **Departments of Human Services/Departments of Social Services** —When utilized, these departments constitute the county's umbrella organization for the provision of a broad array of social services. The departments, in addition, exercise administrative and fiscal oversight, and policy

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[1] *N.J.S.A. 44:7-7* for social services authority and *N.J.S.A. 44:7-76* for Medicaid.

[2] New Jersey Department of Health paper, *Residential Health Care* (1986).

development and planning responsibilities in social service matters. Organizationally, a department is divided into several divisions, each of which handles a different component of social services. Most departments have a mental health division, a veteran affairs division, minority affairs, and a division on aging. The latter in such cases constitutes the county's *Office on Aging.* In four of the charter counties, the *Board of Welfare* has become a division of the department.

• **County Human Services Advisory Councils**—This organization functions as an advisory group to the county government and the New Jersey Department of Human Services. Its primary task involves ensuring that the necessary coordination and comprehensive social service planning takes place within the county. In furtherance of this objective, the council evaluates human services programs and analyzes the human services delivery system. The council's membership is made-up of service providers, public officials, members of voluntary social service agencies, and private citizens, who come together in an effort to improve the quality and coordination of human services.

In overseeing the county's entire human services delivery system, the council grapples with issues affecting the elderly. Many programs have a targeted population of which the eligible elderly constitute a subset. These include victims of abuse and neglect, services for those in poverty, needs of racial minorities, and services for those with emotional disorders as well as the physically disabled. Also, councils directly examine the array of services for senior citizens. Past council efforts have focused on elderly matters such as the need for greater coordination in provision of home health care, greater development of supportive transportation services, improvement in efforts at general case management, a more thorough effort at protective crisis services, and extensions of the outreach program.[3]

• **County Nursing Homes**—One of the most important and expensive services provided by county government for the frail elderly is that of nursing home care. *Twenty-two county nursing homes presently are in existence, with 18 counties having such facilities.* It should be noted that county nursing homes are complemented by the existence of larger numbers of proprietary and non-profit nursing facilities.

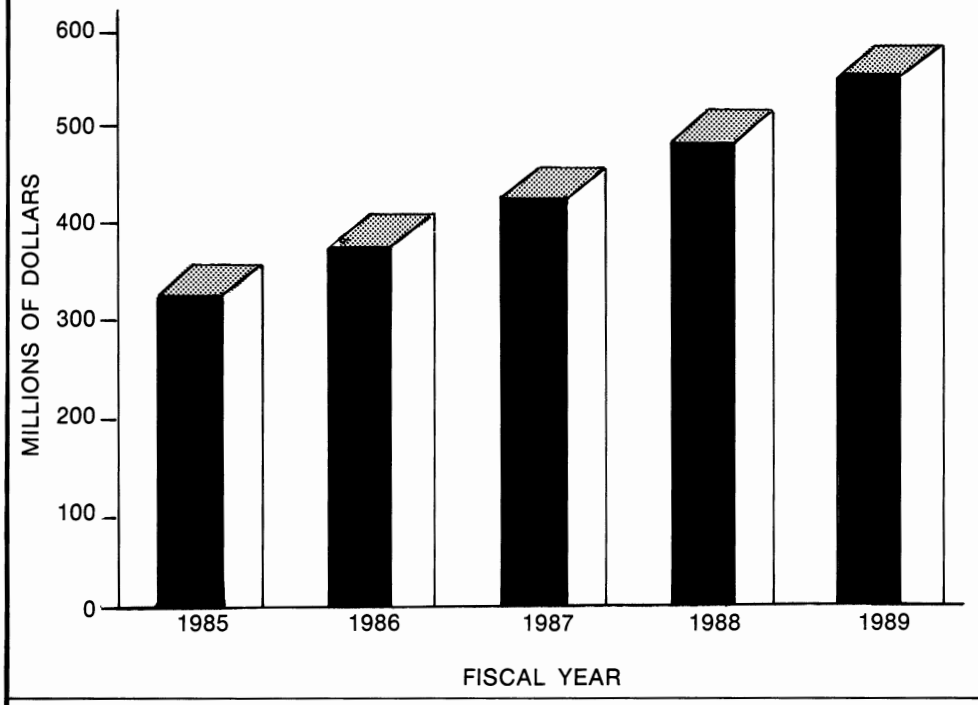
Nursing homes are classified into three categories, depending on their level of care: *Skilled Nursing Facilities* (SNF), and *Intermediate Care Facilities* (ICF) "Level A," and "Level B." *Skilled Nursing Facilities* afford the medically most intensive level of care, serving residents who require ongoing and technology-based medical attention and who are usually infirm. "Level A Facilities" provide care to those who either have ambulatory problems, require medication monitoring, are incontinent, or a combination thereof. "Level B Facilities" house clients who are ambulatory but require some supervision. Compared to their proprietary and non-profit institutional counterparts, county nursing facilities house a greater share of those patients in greater

[3]See, as an example, the *1987 Mercer County Comprehensive Human Services Plan Update* (mimeograph).

GRAPH V-1

NURSING HOME CARE

(ANNUAL MEDICAL ASSISTANCE COST)



Source: *State of New Jersey Budget,* 1988-89.

medical need and those who are indigent. *Of the patients in nursing homes, over 85 percent are 65 years of age and older, with close to 40 percent over 84 years of age.* As of June 1987 there were 4,340 persons residing in county nursing homes.

Nursing home costs are paid for through a variety of means—out-of-pocket expense, Medicare, Medicaid, as well as private insurance. However, ***overwhelmingly the nursing home system is financially underwritten by Medicaid. About two-thirds of the county nursing homes have Medicaid occupancy rates that are over 80 percent.*** Private nursing homes that accept Medicaid must reserve 45 percent of their beds for Medicaid patients. For county nursing homes, the bulk of Medicaid patients are at the "Facility A" level of care. Data from 1982 show that county nursing homes provide service to:

a) one out of four *skilled nursing facilities* patients in the State;

b) one out of every five "Level A" Medicaid patients within the State;

c) one out of every six "Level B" patients within the State; and

TABLE V-1

MEDICAID OCCUPANCY RATES FOR PUBLIC NURSING HOMES IN NEW JERSEY

June 1987
Thirty Days In Period

PROVIDER NAME	NUMBER OF LICENSED BEDS	CENSUS	AVERAGE DAILY CENSUS	MEDICAID OCCUPANCY RATE (%)
Annex—Atlantic County Home (Atlantic County)	96	2,725	88	91.6
Bergen Pines County Hospital (Bergen County)	570	15,000	484	84.9
Buttonwood Hall (Burlington County)	225	5,218	168	74.8
Camden Co. Health Svs. Ctr. Evergreen Manor (Camden)	159	3,776	122	76.6
Red Oak Manor (Camden County)	122	3,053	98	80.7
Crest Haven Nursing Home (Cape May)	140	3,690	119	85.0
Cumberland Manor (Cumberland County)	196	4,861	157	80.0
Essex County Geriatric Center (Essex County)	332	9,930	320	96.5
Shady Lane Home (Gloucester County)	120	2,638	85	70.9
Hudson Co. Meadowview Hospital (SNF/ICF) (Hudson)	110	2,918	94	85.6
Hudson Co. Meadowview Hospital (ICF only) (Hudson)	440	2,918	94	21.4
B. S. Pollak Hospital (Hudson County)	460	12,664	409	88.8
Hagedorn Center for Geriatrics (State Institution)	100	1,926	62	62.1
Mercer County Geriatric Center (Mercer County)	240	6,928	223	93.1
Roosevelt Hospital (Middlesex County)	530	10,950	353	66.6
Montgomery Medical Home (Monmouth County)	195	5,615	181	92.9
Geraldine L. Thompson Medical Home (Monmouth County)	73	2,168	70	95.8
Morris View Nursing Home (Morris County)	362	10,601	342	94.5
Preakness Hospital (Passaic County)	432	12,322	397	92.0
Salem County Nursing Home (Salem County)	110	2,790	90	81.8
Sussex County Homestead (Sussex County)	98	2,851	92	93.8
John E. Runnells Hospital (Union County)	221	4,997	161	72.9
Warren Haven (Warren County)	180	3,986	129	71.4
STATE TOTALS	**5,511**	**134,525**	**4,340**	**78.7**

Source: Untitled data set, Department of Human Services, Division of Medical Assistance and Health Services, June 1987.

d) one out of every five Medicaid days of stay in the State.[4]

Various services are available for those in nursing homes. They include:

1) "medical care" for those who periodically become ill;

2) "nursing services" provided either by a professional nurse or a nursing aide under supervision;

3) "social services" for those needing help with personal or family problems;

4) "rehabilitation services" for those requiring physical, speech or other therapies; and

5) "dietary services" for those requiring a special diet or having particular food preferences.

Under New Jersey Public Law 1976, Chapter 120, a nursing home resident's personal and civil rights are guaranteed. These include a right to confidentiality, a right to visitation, a right to privacy—including sending and receiving unopened mail and private access to a telephone, the right to leave the facility during the day if medically and physically permissible, the right to present grievances without threat of discharge or reprisal, as well as retention of all civil and legal rights.[5]

• **County Psychiatric Hospitals**—***Five of the counties operate their own mental institutions.*** They include Bergen, Essex, Hudson, Burlington, and Camden. Essex County has one of the largest county psychiatric hospitals in the nation.

• **The Surrogate**—The most important responsibility held by the office of surrogate regarding the elderly is the probating of wills. The county surrogate is also involved in determining whether individuals are mentally or physically competent to act on their own behalf. Such individuals can be placed under "guardianship," or in circumstances where they request someone to act as their agent—under "conservatorship." Several surrogates refer elderly persons, who come before them, to programs for which they may be eligible. A small number of counties have a *free-will program*, under which, through grant monies from *Title III* of the Older Americans Act, senior citizens in the county may have their wills drawn up free of charge. The surrogate's office in Union County has an interesting program under which senior citizens are given legal referral, with services made available at a discount rate.

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[4]Much of the above material on county nursing homes was obtained from the New Jersey's Assembly's Corrections, Health and Human Service Committee hearings on *Medicaid Reimbursement for Nursing Homes* (June 25, 1985).

[5]Information on services for and rights of nursing home residents is based on New Jersey's Department of Human Services, *Guide to Long-Term Care and Community Services in New Jersey* (July 1987).

TABLE V-2

AGE-SPECIFIC RATES OF NURSING HOME UTILIZATION

Sex and Age	Rates per 1,000 population Nursing home residence
Male	
65-74	12.7
75-84	47.4
85+	140.0
Total 65+	30.7
Female	
65-74	15.9
75-84	80.6
85+	251.5
Total 65+	59.7

Source: U.S. Congress, Library of Congress, Congressional Research Service, in *Financing and Delivery of Long-Term Care Services for the Elderly,* by Carol O'Shaughnessy, Richard Price, and Jeanne Griffith.

SERVICES PROVIDED BY BOTH COUNTIES AND MUNICIPALITIES

There are numbers of services which are provided by both county and municipal agencies. In some service areas, counties and municipalities coordinate the provision of the particular service. Health is one such example. In others, counties and municipalities maintain and operate their programs detached from the other's efforts. The demarcation or overlapping in responsibilities, of course, varies from county to county. The main service areas are health, educational programs, library services, mental health, and parks and recreational services.

- **County and Municipal Health Departments**—Fourteen counties have health departments. In some counties, the county health department does not provide services to all its municipalities. In such counties, the localities within the county maintain health departments that provide community health services. Approximately 100 municipalities provide local health services to their residents and to the residents of another 100 municipalities which contract with the providing locality for service.

Various kinds of services are provided for senior citizens by county and municipal health departments. Their service orientation is toward screening, referrals and counseling, with local health departments heavily involved with screening and counseling efforts on behalf of the elderly. When referrals are necessary, they usually are made to private doctors and health facilities. Some of the health areas for which screening is common include: problems of hypertension (particularly high blood pressure), blood tests (with special at-

tention paid to cholesterol), visual acuity (mainly glaucoma) and hearing tests, cancer detection, diabetes testing, and flu immunization.

Many county health departments have special health assessment programs for older adults. Areas of medical attention with which they are involved include: cardiovascular problems, chronic diseases, the tracking of a senior citizen's health history, and podiatry problems. Most county health departments run senior citizen health education classes in which seniors are taught health warning signs and how to take better care of themselves. In addition, several county health departments have programs for their senior citizens which are unique to their county. Middlesex's Health Department has a *Vial-Of-Life* program—where the elderly are asked to keep vital prescription drugs in the refrigerator so that officials entering the elderly person's residence in emergencies will be alert to checking the refrigerator for necessary administration of drugs. The Bergen County Department of Health Services operates an *Adult Day Care* program. Atlantic County's Health Department is the case manager for Medicaid's *Community Care Program for the Elderly and Disabled* (CCPED).

While the focus of the county and local health department's task is health screening and counseling, not treatment, an exception to this rule is Camden County and Newark's use of United States Public Health Service doctors to provide direct health treatment to the poor. As a general rule, payments for service are based upon the senior citizen's financial situation. For the indigent, service is free; for others, fees are required or donations requested.

• **Mental Health Boards**—Each county has a **Mental Health Board** which advises the county government and the State's Department of Human Services on the financial needs of the county's mentally ill. In addition, a number of localities have mental health boards. Most county mental health offices contract out while some directly provide counseling and social services for those with mental problems. The preponderance of clients are elderly. The majority of State and county funds for community services are given to nonprofit providers tending to the mentally-ill. Services under the charge of the mental health office, whether it is county, local, or nonprofit, include: individual therapy, family and group counseling, medication monitoring, referrals, outreach and supportive services, arts and crafts activities, self-support training, and support group sessions. Variation in functions exists among the counties and localities.

In Gloucester County, for example, the community health center provides outpatient services and day programs for seniors with emotional problems; supervised and semi-supervised group homes and apartments, and emergency and screening services are provided for those leaving psychiatric institutions. Fees are assessed on a sliding scale, with free services for those unable to pay. In addition, county and local mental health offices are involved in court deliberations on patient institutionalization. In such circumstances, the office presents its assessment of the psychological stability of the patient.

TABLE V-3

REVISED 1990 LONG-TERM CARE BED NEED[1] FOR NEW JERSEY

County/HSA	Total 65+ Population	1987 Existing and Approved Beds[3]	CCPED Slots	Beds Required to Serve Population[2]	Bed Need	Bed Excess
Atlantic/V	33,080	2,060	100	1,500		660
Bergen/I	127,260	4,614	225	4,898	59[6]	
Burlington/V	45,090	1,998	110	1,722		386
Camden/V	62,320	2,646	100	2,392		354
Cape May/V	21,250	848	55	927	24	
Cumberland	19,050	828	40	786		82
Essex/II	100,020	4,242	225	3,909		558
Gloucester/V	25,100	1,237	50	972		315
Hudson/III	71,510	3,323	200	2,860		663
Hunterdon/IV	9,810	597	15	387		225
Mercer/IV	43,790	1,724	85	1,746		63
Middlesex/IV	81,060	3,358	135	2,874		819[4]
Monmouth/IV	78,700	3,640	120	3,367		393[5]
Morris/II	45,940	2,499	45	1,928		616
Ocean/IV	104,400	4,235	175	4,929	519[5]	
Passaic/I	60,250	3,211	140	2,488		863[6]
Salem/V	9,810	678	20	402		296
Somerset/IV	25,320	1,523	30	994		359[4]
Sussex/II	13,670	981	25	601		405
Union/II	74,950	3,222	150	2,876		496
Warren/II	12,990	653	30	542		141
STATE	**1,065,370**	**48,117**	**2,075**	**43,101**		**7,091**

[1]Revised May 4, 1987. Includes approvals for CN applications reviewed at the 1/30/87 SHCC.
[2]Pursuant to NJAC 3:33H-3.10.
[3]Does not include eleven (11) facilities with a total of 1,359 (licensed and/or approved) beds which are classified as "restricted admission," or pediatric LTC, nor thirteen (13) life-care facilities with a total of 840 beds which are exempt. Does not include beds currently under review and pending Commissioner's approval.
[4]Based on an approved waiver request by HSA IV, 200 beds currently existing in Somerset County but primarily serving Middlesex County residents are considered allocated to Middlesex County.
[5]Based on an approved request by HSA IV, Monmouth and Ocean counties are combined for a regional net bed need.
[6]Used as regional need; Bergen and Passaic are combined for a regional net bed need.

Source: N.J. Department of Health, *Health System Review—1987.*

TABLE V-4

REVISED 1990 LONG-TERM CARE BED NEED FOR NEW JERSEY

County/HSA	1990 Population 65-74	1.2 Beds/ 100 Population	1990 Population 75-84	5.2 Beds/ 100 Population	1990 Poulation 85+	18.1 Beds/ 100 Population
Atlantic/V	18,110	217	11,060	575	3,910	708
Bergen/I	78,430	941	27,840	1,968	10,990	1,989
Burlington/V	28,570	343	12,490	649	4,030	729
Camden/V	38,400	461	18,590	967	5,330	965
Cape May/V	11,740	141	7,250	377	2,260	409
Cumberland/V	11,060	133	6,150	320	1,840	333
Essex/II	61,140	734	29,940	1,557	8,940	1,618
Gloucester/V	15,530	186	7,340	382	2,230	404
Hudson/III	43,030	516	21,790	1,133	6,690	1,211
Hunterdon/IV	5,990	72	2,920	152	900	163
Mercer/IV	26,440	317	13,270	690	4,080	738
Middlesex/IV	52,770	633	22,320	1,161	5,970	1,081
Monmouth/IV	45,580	547	24,610	1,280	8,510	1,540
Morris/II	27,480	330	13,510	703	4,950	896
Ocean/IV	50,860	610	41,640	2,165	11,900	2,154
Passaic/I	35,660	428	18,530	964	6,060	1,097
Salem/V	5,760	69	3,100	161	950	172
Somerset/IV	15,740	189	7,200	374	2,380	431
Sussex/II	7,770	93	4,340	226	1,560	282
Union/II	46,260	555	22,260	1,158	6,430	1,164
Warren/II	7,540	90	4,150	216	1,300	235
STATE	**633,860**	**7,606**	**330,300**	**17,176**	**101,210**	**18,319**

Source: N.J. Department of Health, *Health System Review—1987.*

Educational Programs For Senior Citizens

County and local educational institutions provide training and liberal arts courses for senior citizens. While some of these programs are specifically geared for senior citizens, the overwhelming majority are offered for the general adult population. Also, county and local educational institutions provide senior citizen discounts for numbers of their offerings. Among counties, two kinds of institutions make available educational programs for senior citizens—county colleges and county vocational schools.

- **County Vocational Schools**—Twenty New Jersey counties have county vocational schools. Their senior citizen programs consist of night classes oriented toward technical training. However, a broad array of course work is available, including both technical training and personal enrichment courses. Some examples are: English for the foreign-born, high school curriculum courses leading to a high school diploma, secretarial courses, preparatory courses for the State high school equivalency test; enrichment programs in such areas as crafts, music appreciation, foreign language course work, aerobic classes, and cooking instructions. Many of the county vocational schools provide senior citizen discounts or no charges for course registration. Middlesex's vocational school program has a noteworthy offering for seniors. It combines beauty shop care with lunches for elderly women. Seniors also get a discount upon utilizing the dry cleaning service.

- **County Community Colleges**—The county colleges offer a broad assortment of courses, some designated specifically for senior citizens. Many of the senior citizen targeted programs are self-advancement and personal enrichment type courses. Samples of these courses include "wills and estate planning," "aerobics," "art for senior citizens," "real estate," "money management for retirees," and "creative writing." One of the more interesting programs is in Ocean County where the county community college holds a *senior ventures* program—a three-day combination of art appreciation, self-development and human history courses, which take place all day on campus with lunch and recreational activities interwoven into the day's schedule. Ocean County also operates an art appreciation-site visitation program, with trips scheduled to top museums such as the Museum of Modern Art.

- An innovative and highly successful job placement program is operated by Middlesex Community College. Titled ***Project Resources,*** it links employers, interested in filling job openings, with senior citizens, seeking full and part-time, or temporary positions. The program, which is oriented toward those not meeting the income eligibility criteria of *Title V* of the Older Americans Act, has placed over 200 low-income and middle-income senior citizens in meaningful positions. Senior citizen applicants are given training sessions that concentrate on preparation of a resume and job interviewing pointers, and some technical training such as secretarial preparation and computer usage.

- **Local School Districts**—Many seniors avail themselves of adult evening education courses which are offered by numbers of local school districts. These run the gamut from vocational courses, to high school curriculum

courses, to personal enrichment courses. Numbers of public schools offer senior citizen discounts.

• **Local Libraries**—County and local libraries have circulating collections of books, musical recordings, film and video collections that are available on loan to local residents. In addition, information and referral services on public agencies, social clubs and organizations are available, including published directories of organizations within the community. A number of libraries have special programs; examples are a speaker and movie series, and music programs. The Morris County Library has a set of programs for the elderly and infirm. They include: a book loan program for nursing home and other institutionalized residents (open to participating localities in the county), a special large-type book collection for seniors and others with visual acuity problems, a *focal-kit package*—which constitutes a multi-media presentation before groups on historical periods in America, a *book by mail* program for the homebound, and a service center for the blind and handicapped.

• **County and Local Departments of Parks and Recreation**—*Departments of Parks* have programs open to all residents as well as programs targeted specifically at senior citizens. Regarding the latter, there is a broad range of activities specifically for senior citizens. They include: long distance trips, aerobic classes, arts and crafts activities, walking clubs, organized games for seniors, senior theater programs, a naturalist program. Some of the programs operated by the county parks department are packaged directly for senior citizen centers. Special mention needs to be made of Monmouth County's park system, which is in the forefront in its extensive offering of senior citizen oriented programs.

In addition, there are park and recreational activities for which the elderly receive discount rates. Two of the more common are for swimming facilities and golf courses. There are several, ongoing park department-sponsored activities for which senior citizens constitute good numbers of the participants: they include horticulture activities, organized hikes and park tours, fishing and boating activities, concerts for the public, use of ice skating arenas, and naturalist programs.

ROLE OF MUNICIPALITIES

With 567 municipalities in the State of New Jersey there is considerable variation in the services they provide for their elderly population. Much of the variation is rooted in the size of the municipality, their financial solvency, and general receptiveness toward social service provision. The range in elderly programs and services runs the gamut from no special services for the elderly to fairly substantial offerings in elderly programs.

All New Jersey municipalities provide general services for their residents, which include the elderly. Among these basic municipal services are public safety, parks, recreational and public works programs. Many high schools have evening offerings in which the elderly take classes. Also, many local libraries find that seniors are among their most active clientele. Senior citizens, as residents, are the recipients of these local services which are paid for out of

TABLE V-5

NEW JERSEY MUNICIPALITIES WITH TWENTY PERCENT OR MORE OF ITS POPULATION 65 YEARS OLD AND OVER, 1980

MUNICIPALITY	COUNTY	ALL PERSONS	PERSONS 65 YEARS OLD AND OVER	
			NUMBER	PERCENT
Manchester Twp.	Ocean	27,987	15,027	53.7
Cape May Point Boro	Cape May	255	102	40.0
Longport Boro	Atlantic	1,249	475	38.0
Berkeley Twp.	Ocean	23,151	8,741	37.6
Stone Harbor Boro	Cape May	1,187	412	34.7
Pahaquarry Twp.	Warren	26	8	30.8
Corbin City	Atlantic	254	76	29.9
Long Beach Twp.	Ocean	3,488	1,030	29.5
Surf City Boro	Ocean	1,571	447	28.4
Avon-by-the-Sea Boro	Monmouth	2,337	635	27.2
Southampton Twp.	Burlington	8,808	2,377	27.0
Ocean City	Cape May	13,949	3,639	26.1
Lavallette Boro	Ocean	2,072	540	26.1
Harvey Cedars Boro	Ocean	363	92	25.3
Ocean Twp.	Ocean	3,731	944	25.3
West Cape May Boro	Cape May	1,091	274	25.1
Mantoloking Boro	Ocean	433	108	24.9
Lakewood Twp.	Ocean	38,464	9,444	24.6
Ship Bottom Boro	Ocean	1,427	350	24.5
Beach Haven Boro	Ocean	1,714	416	24.3
Barnegat Light Boro	Ocean	619	150	24.2
Seaside Park Boro	Ocean	1,795	428	23.8
Atlantic City	Atlantic	40,199	9,446	23.5
Cape May City	Cape May	4,853	1,127	23.2
Avalon Boro	Cape May	2,162	490	22.7
Spring Lake Hgts. Boro	Monmouth	5,424	1,219	22.5
Red Bank Boro	Monmouth	12,031	2,698	22.4
Ventnor City	Atlantic	11,704	2,623	22.4
North Wildwood City	Cape May	4,714	1,040	22.1
West Wildwood Boro	Cape May	360	79	21.9
Point Pleasant Beach Boro	Ocean	5,415	1,185	21.9
Monroe Twp.	Middlesex	15,858	3,455	21.8
Sea Girt Boro	Monmouth	2,650	571	21.6
Margate City	Atlantic	9,179	1,969	21.5
South Belmar Boro	Monmouth	1,566	334	21.3
Belmar Boro	Monmouth	6,771	1,441	21.3
Haledon Boro	Passaic	6,607	1,400	21.2
Springfield Twp.	Union	13,955	2,953	21.2
Lower Twp.	Cape May	17,105	3,503	20.5
Interlaken Boro	Monmouth	1,037	209	20.2
Asbury Park City	Monmouth	17,015	3,409	20.0
Ocean Gate Boro	Ocean	1,385	277	20.0

Source: *Census of Population, 1980.*

general revenue, with State, Federal, and county aid forthcoming in some cases. Municipal health programs provide particular benefit to elderly residents. In addition to the general screening and health assessments available to the public, some locations have specialized services for senior citizens. These include blood pressure and diabetic screening, clinic sponsored health presentations dealing with elderly concerns, and blood tests. Regarding public transportation: the elderly of Newark receive senior citizen discounts on subway use as do some of the elderly in shoreline areas with jitney services. Many municipalities have senior centers in which elderly residents have their own organization and set of activities.

It is important to note that there is an extensive array of services offered by the larger municipalities. Some of the services provided are funded by county monies, particularly through the Office on Aging which contracts out many services, and through State and Federal grants. Here is a sample of the services offered for seniors by municipalities.

• **Atlantic City** (Atlantic County) One of the most extensive set of programs for senior citizens is provided by Atlantic City. Several services are available to all residents of Atlantic City of which the elderly are major beneficiaries. A primary one is the City's public health clinics. Atlantic City's public library program operates a literacy program as well as arts and crafts classes. There is a legal assistance program. Also, the City runs numbers of public recreational activities which are utilized by many senior citizens.

In addition, there are major sets of programs operated by Atlantic City Government that are specifically designated for senior citizens. One service, funded with *Title III-B* money from the Older Americans Act via the Atlantic County Area Agency on Aging, consists of a set of *outreach* programs. There is an *information and referral* component where City employees go out to individual homes and senior citizen buildings to acquaint the needy elderly with the available programs for which they may be eligible. Approximately 2,000 people a year are reached through this program. Another program consists of bimonthly food shopping trips for the homebound, who because of their medical condition or physical disabilities are unable to attend to grocery shopping.

As a grantee of the Atlantic County Area Agency on Aging, Atlantic City's Office on Aging also provides administrative assistance in determining the elderly's eligibility and helping them fill out the application forms for *Pharmaceutical Assistance to the Aged and Disabled, Home Energy Assistance,* and *Supplementary Security Income.* The Office also conducts a *telephone reassurance program* where homebound seniors receive at least one call a week. There is also an *escort and transportation service* which provides help in crucial situations for those needing transportation to or from a hospital, a doctor's office, or a social service agency. The Office also operates a food commodities distribution operation a couple of times a year for the needy. There are recreational and social programs made available to the elderly. There is also a program where senior citizens serve as counselors for youngsters at nursery schools.

The City's Office on Aging also operates a transportation service for those elderly without access to transportation. Here senior citizens are provided the

means to go to the bank, supermarkets, doctors' offices and medical centers. Vans are provided that take seniors from major locations, such as senior citizen housing developments and central street intersections, to business areas and specific facilities. Those that are infirm are provided with door-to-door service.

In a cooperative agreement with the Atlantic County Area Agency on Aging, the City Office operates both the *Meals on Wheels* and *Congregate Meals* programs. The *Meals on Wheels* program provides meals to the homebound elderly Monday through Friday. Two-thirds of the Program's costs are presently paid for by City monies. In addition, through the Atlantic County Area Agency on Aging, the City receives Casino Revenue Funds to provide weekend meals to the frail elderly. The *Congregate Meals Program* provides meals at senior citizen centers and presently serves approximately 60 seniors a day. In addition, the centers provide speakers and day trips for senior citizens.

- **Bloomfield Township** (Essex County) has several mental and physical health programs for the elderly. They include psychological therapy sessions with a clinical social worker. There is an ongoing effort to seek out those in the community that need such services. Sessions are also held with caregivers to the infirm elderly on an ongoing basis. Though the clinical social worker position is funded by the *County Office on Aging*, Bloomfield Township complements this project with its own funded mental health outpatient therapy and outreach programs. The Township's Nursing Division, within the Department of Health and Human Services, conducts home visits by nurses for the elderly homebound, with screening and referral given. The Township also provides senior citizens with a speakers' program on health topics. Also referrals are provided for social service programs for which seniors may be eligible.

- **Morristown** (Morris County)—One of the most noteworthy and established municipal senior offices is Morristown's. Its Division on Aging was established as a pilot project 15 years ago and has served as a national model for the kind of local senior center envisioned by the national Administration on Aging—one providing a broad array of social services. It has a full-time staff of four, and all of its funding for locally sponsored programs comes from Morristown's Government.

Among the services it provides, are: transportation, informational and referral, case management, family counseling, cultural trips, assistance with application forms, personal counseling, an annual senior citizen picnic, home-delivered meals, and retirement counseling. It also distributes a monthly newsletter to 1,500 senior citizens. It is worthy of note that Morristown is the county leader in introducing senior citizen housing within the County.

- **New Brunswick** (Middlesex County) operates its Senior Resource Center with a full-time staff of four. The Center offers medical educational talks on a regular basis. Its recreational activities include: bocce, shuffleboard, exercise classes, dance classes, handicraft-making, sewing, quilting, painting and ceramic-making classes, weekly movies are shown, bingo is held, and the Center has a senior citizen chorus group. It serves over 100 senior citizens

a day. Of the $60,000 annual budget, $35,000 comes from the City and $25,000 from the *County Office on Aging.*

The Center sponsors food shopping trips twice a week, engages in "informational" and "referral" efforts, and it provides medical screening. Breakfasts and lunches are available at the Center. Once or twice a month, chartered trips are undertaken under the sponsorship of the Senior Resource Center. A monthly newsletter for seniors is put out. The Center also participates in the food commodities program, whereby food is distributed to the needy.

- **Ridgewood Village** (Bergen County) has numbers of programs for the elderly, the majority of which are sponsored by the Village's recreation center. The orientation is toward providing information and entertainment for senior citizens. One of the major services for seniors performed by Ridgewood Village Government is that of "referral" to the appropriate service institution. Among the programs operated by the center are exercise classes, arts and craft activities, and dancing sessions. Monthly trips for cultural activities and dinner theater shows are provided, with senior citizens also having available two extended trips (a week to ten days in a distant city or resort area) a year. Transportation costs are borne by the Town. The locality is shortly due to begin operating *County Office on Aging* and State sponsored programs for senior citizens. These include: the *Senior Health Insurance Program* (SHIP) and *Meals on Wheels.* Ridgewood Village makes available annual flu shots for seniors, free of charge. The recreation center sponsors an annual picnic and Christmas party for the elderly. Utilization of the town's pool is available for senior citizens with the annual fee waived.

- **Camden** (Camden County)—Camden's Office on Aging originated in the early 1970's. Last year's annual budget was $37,000 of which $15,000 came from a Community Development Block Grant given to the City, with the Office servicing over 10,000 senior citizens a year. The major two functions performed by the Office are "information and referral" and transportation services for food shopping. Regarding the latter program, seniors are picked up at several central locations for food shopping, to which they are returned. These locations include the more than half-a-dozen public high-rise buildings which house close to 2,000 seniors. In addition, the head of the Aging Office serves as Camden Government's municipal coordinator for elderly concerns—a position which gives her liaison responsibilities with all appropriate Camden Government agencies.

Other Camden Office on Aging operated activities include: assistance with application forms, an annual Christmas Party, two or three senior citizen day trips a year, with as many as 12 bus loads of senior participants. In conjunction with the City's Health Department, medical screening is regularly provided for seniors with blood pressure problems, eye and ear concerns, and podiatry ailments. There is an office of recreation within the City that sponsors social activities for seniors. Also, the City's Department of Housing Services provides home repairs for low-income residents through Community Block Grant funding, and functions as an advisor on housing loans for the City's low-income residents. The elderly constitute a good share of the program participants.

• **Elizabeth City** (Union County) has an office on elderly affairs providing "informational" and "referral" services. It also operates a bus service which provides shopping transportation for seniors, rotating the neighborhood receiving the services on a daily basis. The elderly office also issues an identification card for seniors which aids them in their application for public assistance. Elizabeth City participates in the *home energy assistance program*, which provides home heating insulation for the elderly.

The City is nearing completion on the construction of a senior citizen center. Its funding for programs come overwhelmingly from municipal government. Hearing aids and glasses are collected for the needy. The office on elderly affairs also provides bus transportation for cultural activities. It sponsors a *Senior Citizen Jamboree* annually which consist of a picnic lunch and health screening. Also, a Christmas party is held for seniors each year.

• **Belleville Township** (Essex County) has several general programs which aid good numbers of senior citizens. Its health clinic and community mental health center serve many elderly. The elderly are major recipients of the *home energy assistance program*, which is funded by county government and the *food commodity* program (which distributes food parcels to the needy four times a year). Belleville has senior citizen discounts for its public transportation system.

• **Manchester Township** (Ocean County)—There are at least 14 retirement communities in Manchester Township. The Township has two major functions it performs for the elderly: information and referral, and medical transportation services. In addition to transportation for medical care, the town also does bimonthly grocery shopping for the elderly homebound. Senior citizens are assisted in filling out Medicare and *Pharmaceutical Assistance to the Aged and Disabled* applications.

• **Monroe Township** (Middlesex County) provides several services for its elderly population. One of the most important, in terms of its effects on the quality of life, is weekly transportation to medical facilities. Shopping transportation is also available on a weekly basis. The buses for these trips are leased from Middlesex County, with the town operating the service. Major effort is expended at contacting elderly residents and apprising them of the services for which they are eligible. It should be noted that the Township has five adult retirement communities within its borders. Monroe Township is in the process of completing the construction of a senior citizen center. When it is completed, hot lunches will be available in the facility.

The Township offers health screening on a regular basis. Medical staff is brought in to conduct oral cancer screening and eye and hearing tests. There is also a senior citizen tax counseling program, whereby senior citizens are trained to provide tax counseling to the rest of the elderly community. Monroe Township also operates recreational and educational day trips for elderly residents.

ROLE OF HOUSING AUTHORITIES

Housing authorities assist senior citizens of low-income by providing public housing or publicly assisted housing. There are several types of housing

authorities in New Jersey. Each individual municipality has the power to establish its own local housing authority. In 1982, 78 municipal housing authorities and four county housing authorities were in existence. Many other municipalities and counties provided publicly subsidized housing to low and moderate income individuals, which include the elderly. It should be noted that county housing authorities can only operate in consenting municipalities which do not have their own housing authority. Conversely, once a county housing authority has been established, municipalities within that county cannot establish their own local housing authority without the permission of the county governing body and the county housing authority.

In each case, the local housing authority is governed by an appointed seven-member commission. All such authorities are empowered to issue bonds, set and collect charges for use of their facilities, and garner grants and other monies from the Federal Government and other organizational bodies. Many of the 78 municipal housing authorities in the State have facilities exclusively reserved for the elderly. Figures for 1984 show that 45,000 units of publicly owned or subsidized housing exist for the elderly in the State (Table V-6).

Within New Jersey's 21 counties, ***elderly subsidized housing is concentrated in Essex, Monmouth, Hudson, Middlesex, Passaic and Bergen Counties.*** Of a total of 328 subsidized apartment buildings for the elderly, in 154 communities in the State, Essex County has 56 buildings in 12 communities, Monmouth has 36 buildings in 19 communities, Hudson has 30 buildings in seven communities, Middlesex has 26 buildings in 15 communities, Passaic has 24 buildings in five communities, and Bergen has 24 buildings in five communities (Table V-7).

TABLE V-6

NEW JERSEY SUBSIDIZED HOUSING FOR THE ELDERLY (1984)

45,539	—	Total Units
19,941	—	Public Housing
17,073	—	State Assisted Housing
8,525	—	Federal Assisted
42,080	—	Total Elderly Occupied
29,826	—	Single
6,211	—	Couples
2,289	—	Units Under Construction
2,854	—	Units Planned
55,158	—	Waiting List Total
8,869	—	Couples
30,724	—	Single Occupancy

Source: N.J. Division on Aging, *Survey of Subsidized Housing, 1984.*

New Jersey State Library

TABLE V-7A

SUBSIDIZED HOUSING PROJECTS FOR THE ELDERLY (1984)

NUMBER COMMUNITIES		NUMBER BUILDINGS	TOTAL WAITING LIST	TOTAL SUBSIDIZED UNITS	NUMBER UNITS UNDER CONSTRUCTION	NUMBER UNITS PLANNED
5	Atlantic	14	1,032	2,205	164	150
17	Bergen	24	5,546	2,731	34	254
5	Burlington	5	432	407	7	24
13	Camden	17	2,770	1,929	90	20
3	Cape May	8	775	648	0	652
3	Cumberland	6	775	1,162	240	100
12	Essex	56	15,764	11,322	0	201
5	Gloucester	7	315	423	100	0
7	Hudson	30	4,404	6,083	575	410
3	Hunterdon	4	149	149	0	0
5	Mercer	17	1,005	2,514	197	0
15	Middlesex	26	4,069	2,657	172	150
19	Monmouth	36	7,824	4,049	0	100
8	Morris	10	1,551	1,059	138	233
5	Ocean	9	561	710	134	40
5	Passaic	24	4,158	3,073	0	0
4	Salem	5	13	436	0	100
4	Somerset	4	626	440	113	0
3	Sussex	2	68	230	40	0
10	Union	18	2,992	3,028	165	340
3	Warren	6	329	284	120	80
154	Totals	328	55,158	45,539	2,289	2,854

413 Communities without subsidized housing in N.J.
Source: N.J. Division on Aging, *Survey of Subsidized Housing, 1984.*

TABLE V-7B

SUBSIDIZED HOUSING PROJECTS FOR THE ELDERLY (1984)

	TOTALS		LOCAL HOUSING AUTHORITIES		HOUSING AND FINANCE MORTGAGE AGENCY		OTHER FEDERAL	
	Units	Waiting List	Units	Waiting List	Units	Waiting List	Units	Waiting List
Atlantic	2,205	1,032	946	425	759	128	500	479
Bergen	2,731	5,546	1,689	2,452	459	2,168	583	926
Burlington	407	432	50	2	0	0	357	430
Camden	1,929	2,770	671	1,025	883	1,046	375	699
Cape May	648	775	271	183	205	420	172	172
Cumberland	1,162	775	1,063	670	0	0	99	105
Essex	11,322	15,764	4,606	699	5,137	12,709	1,579	2,356
Gloucester	423	315	419	313	0	0	4	2
Hudson	6,083	4,404	3,547	1,955	1,798	1,519	738	930
Hunterdon	149	149	0	0	0	0	149	149
Mercer	2,514	1,005	621	122	849	783	1,044	100
Middlesex	2,657	4,069	872	1,128	993	1,451	792	1,490
Monmouth	4,049	7,824	1,418	1,740	2,310	4,544	321	1,540
Morris	1,059	1,551	385	229	292	615	382	707
Ocean	710	561	542	328	0	0	168	233
Passaic	3,073	4,158	821	277	1,313	3,169	939	712
Salem	436	13	339	13	0	0	97	0
Somerset	440	626	40	30	400	596	0	0
Sussex	230	68	80	52	150	16	0	0
Union	3,028	2,992	1,349	551	1,525	2,270	154	171
Warren	284	329	212	79	0	0	72	250
Totals	45,539	55,158	19,941	12,273	17,073	31,434	8,525	11,451

Source: N.J. Division on Aging, *Survey of Subsidized Housing, 1984.*

Regarding units under construction and planned for construction, there are a combined total of over 5,100 such units. Of the total, about 1,000 units are in Hudson County, over 500 in Union County, close to 400 in Morris County, and approximately 300 units each in Atlantic, Bergen, Cumberland, and Middlesex Counties. The 5,100 housing units for the elderly expected to be available in the near future compares with a present day waiting list of over 55,000 elderly who seek entry to public housing (Table V-7). The numbers on the waiting list can only be expected to grow as the projected increases in New Jersey's elderly population is realized.

In most cases there is an array of social services available for senior citizen residents. They include "information and referral," emergency home visits, counseling, chore services for those unable to provide their own personal grooming and cooking, homemaker services for those who cannot perform their own housecleaning, educational programs, transportation to medical facilities and for other major matters needing attending to, congregate meals on the premises, and health services. Much of the funding for these services comes from outside sources, such as Older Americans Act monies, county funding, State aid or Federal block grants.

SUMMARY

County and municipal agencies, in recent years, have assumed greater responsibilities in the field of elderly services. The county role runs the gamut from welfare and human services. educational offerings, legal counseling, to health care and mental health services. The potential for much greater cohesion in addressing problems of the elderly regarding social service assistance is there. New Jersey counties are moving slowly toward greater coordination and integration in the provision of human services.

One of the most important and expensive services provided by county government for the elderly is that of nursing home care. Presently 18 counties have nursing home facilities. There are also county and municipal operated health departments, with a primary focus on "screening," "referrals" and "counseling." Many county health departments have special health assessment programs for senior citizens.

Another major category of county services for senior citizens is in the educational field. County vocational schools, for example, offer both technical training and personal enrichment courses that are attended by seniors. Some county community colleges offer special courses for seniors. County departments of parks and recreation organize many kinds of activities specifically for seniors.

There is great variation in the services municipalities provide for their seniors. In general, municipalities, that do provide services, provide one or more of the following for the elderly: "information and referral," health screening, recreational and cultural activities, and transportation services for medical needs and food shopping. Local school districts offer a number of programs of interest to the elderly. Housing authorities play an important role in providing subsidized public housing for the low and moderate-income elderly.



CHAPTER VI
SUMMARY AND RECOMMENDATIONS

I. SUMMARY

This report has provided a profile of New Jersey's elderly and examined the range of programs and governmental institutions that service New Jersey's senior citizens. Our focus has been on the role played by New Jersey local government. As has been made obvious from the report's discussion, great governmental effort and not insignificant expenditures have been forthcoming. New Jersey governments have in place a broad array of programs, with both State and local governments having shown a strong commitment to aid the State's senior citizens.

In responding to the needs of New Jersey's elderly, joint State-local efforts have been initiated to deal with the most pressing problems of the elderly. In the vital areas of health care, social and economic needs, adequate shelter and food, State and local governments have combined forces to alleviate many sorts of hardships faced by the elderly. In large numbers of cases, county monies, supplemented by State funding, have resulted in county efforts to tend to the outstanding problems of the State's seniors.

County involvement with elderly concerns is rooted in two divergent approaches. One is a coordinated intergovernmental approach, supported by county, State and Federal funding, in which county administrative effort and oversight define the operation of the programs. Here, the objectives are intergovernmentally-shared by the three levels of government, with the administration of these programs marked by uniformity of purpose and eligibility standards.

Four kinds of programs come under the purview of this intergovernmental network: 1) *access services*, 2) *nutrition services*, 3) *home support services*, and 4) *community support services*. Each County Office on Aging directs the provision of services and is the major institutional actor in each of these four categories.

Access services link the elderly in need with the appropriate providers of these services. The major access functions are information and referral, extending contact to the elderly, and provision of transportation services. Nutrition services, which consist of two distinct programs, provide meals for those elderly unable to prepare their own food. One, the *congregate meal program*, provides meals to those elderly in nutrition centers; the other, *meals-on-wheels*, provides home-delivered meals.

Home support services are designed to meet the essential needs of the homebound elderly. They consist of personal and medical care, residential

upkeep and home maintenance assistance. The intent of these services is to enable elderly persons to maintain themselves among family and friends in the community rather than have to undergo institutionalization.

Community support services play a role similar to that of home support services—fulfilling critical personal needs of the senior citizen, except they have a larger orientation, that of enabling the individual to function in his or her social setting. Major community support services are: health screening, recreational activities, legal assistance, and protective services.

In contrast to the intergovernmental format, the second approach to meeting the needs of the elderly is an individualistic one. Here, acting on their own, county and municipal governments have established various programs that aid the elderly. Many of these programs play a major role in meeting elderly needs. By far the most important role is the counties' operation of nursing homes. There are 22 county operated nursing homes in the State, with 18 counties having such facilities. County nursing homes provide close to 5,500 beds, approximately 15 percent of total nursing home beds in New Jersey. In addition, they serve the poorest and most ill segment of the nursing home population.

Another major function, that of health screening and health assessment, is performed by county and municipal health departments. Counties and municipalities, through their respective school boards, offer courses that are often taken by the elderly. There also are recreational programs sponsored by county and municipal governments that serve senior citizens. County park departments are the dominant agent in this regard for the county, while municipalities sponsor these kinds of activities out of their recreation departments.

II. RECOMMENDATIONS

Although these efforts constitute substantial progress, a review of what has been accomplished nevertheless reveals that there are severe adverse conditions affecting New Jersey's senior residents still in need of address. It is within this context that we offer our recommendations concerning future efforts.

The recommendations of this report are based on a cognizance of the need to strike a balance between the outstanding needs of the State's elderly and the fiscal capability of the State and localities to address these deficiencies. Much of what we do regarding recommendations constitutes a prioritizing of the unmet needs of the State's elderly.

The Commission's examination of the services provided to New Jersey's senior citizens leads us to the conclusion that there are two major gaps in the present array of programs for senior citizens—gaps in health care provision and deficiencies in approaches that interconnect housing and income needs. In the health field the overwhelming need is for approaches that make the utilization of long-term care services more cost-efficient and that help underwrite the financial costs of long-term care. In the housing field, mechanisms need to be developed that both address the income needs of

elderly homeowners and the housing needs of the low-income elderly. Within the housing category, there is also a need to advance mechanisms which enable the elderly to utilize the equity, accumulated through their home-ownership, to alleviate cash flow problems in their later years.

NEED FOR GREATER EMPHASIS ON LONG-TERM CARE

Though the past few decades have witnessed great strides in addressing the medical problems of the elderly, one major outstanding problem, that of *long-term care*, still awaits governmental attention.[1] Long-term care issues concern appropriate and sustained long-term help for those elderly persons whose chronic illnesses or physical disabilities limit their ability to live independently. Without assistance these individuals would lead lives of abject misery or be forced to undergo institutalization. Services subsumed under long-term care include health, social, and personal care services. For the non-institutionalized elderly, long-term care services can include homemaker and home health services, medical and social day care, respite care, and medical transportation. Unlike issues of acute care, there is no imminent medical danger to the individual, rather the problem is one of ongoing health and physical disability.

Difficulties in Expanding Long-Term Care Coverage

Past financial and institutional restraints have produced an inability on the part of of New Jersey to fully address this issue. Foremost among these is the past development of a system of health care directed almost exclusively toward provision of intensive health services within the institutional setting. The locus of service provision has thus become the hospital, nursing homes and lower level care facilities. Sustaining the system of institutional care are Federal eligibility requirements based on institutional provision, reinforced by public reimbursement mechanisms oriented toward such care, with non-institutional providers the recipients of public frugality. Eligibility requirements, as reflected in public financing practice, have strengthened the bias toward use of institutional facilities and the placement of the infirm elderly in such facilities rather than providing them with services in a home or community setting. The development of an overriding system of institutional care and governmental orientation toward such care have served to impede the development of a more extended system of long-term care.

A second element inhibiting the expansion of long-term care are its potential costs. At present, over 70 percent of long-term care is provided privately by family and friends. Any wholesale availability of publicly-financed, long-term care services has the potential of sharply increasing New Jersey health care expenditures. The need for long-term care services must be balanced by the prohibitive financial costs associated with their unrestrained provision. Budgetary considerations thus constitute a major impediment in establishing an extensive system of long-term care.

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[1]With the passage of a catastrophic health-care plan at the Federal level, this major problem has been addressed, thus leaving *long-term care* as the major remaining health issue for the elderly.

Financial Savings in Overhauling the Present Long-Term Care System

While recognition of overall budgetary constraints is important, this perspective must be tempered by the fact that there are potential financial savings in extending and increasing coverage for community and home care. The institutional bias of Medicaid and Medicare toward nursing home care has produced an over utilization of long-term care facilities by those elderly able, and for the most part desiring, to receive less confining levels of care. For the eligible senior citizen, such care would be less restrictive, affording the individual greater freedom. National studies have shown that between 10 and 18 percent of the elderly admitted to nursing homes could live in their homes if the appropriate community-based and home support services were available.

Presently in New Jersey, almost two-thirds of the nursing home patients and about half of nursing home costs are borne by the State's Medicaid program. The increase in costs of nursing home care has been staggering, presently constituting about $485 million or 36 percent of Medicaid's budget, with such care going disproportionately to a small percentage (4.5 percent) of Medicaid recipients. In fact, ***Medicaid expenditures for New Jersey nursing home care has increased at an average annual rate of 18 percent from 1981 to 1987, jumping from $218 to $452 million.*** Increases of the past two years have been at a rate of about 14 percent. Current projections place 1992 combined individual and Medicaid expenses for nursing home care at over two billion dollars for the year.

A 1977 study of the State Medicaid program revealed that 35 percent of Medicaid patients at just one level of care, Intermediate Care Facilities-B (one of the subcategories of nursing homes), could be placed in less intensive levels of care at a saving of 62 percent ($39.2 million versus $15.2 million). In addition there are great differences in construction costs: total construction costs per nursing home bed is $28,000 while residential health care costs per bed is only about $11,000. Overall, the costs of providing community-based care and home care come to about a third of those of costs in an institutional setting.

Figures for the distribution of long-term care services are as follows:

PROVIDERS OF LONG-TERM CARE*

Number of Institutions	Level of Care	Patient Capacity
306	Long-Term Care Facilities (nursing homes)	37,500 beds
254	Residential Health Care Facilities (Lower level care facilities)	9,500 beds
3,500	Boarding Homes	30,000 residents
60	Home Health Agencies	188,000 patients

*The numbers for home health agencies are for 1985, while the figures for the rest are for 1984.

Recognizing the substantial savings that can be realized by a more balanced long-term care system and cognizant of the desire of the elderly to retain as much independence as possible, both Federal and State governments have cautiously sought to reorient health care provision toward a more balanced system. The Federal Government, in a measure affecting all the states, has encouraged a trend toward home and community-based services through its Medicaid 2176 waiver, which allows those in need of institutionalization to be provided such services. Taking advantage of such a waiver, the State of New Jersey has extended its home-care and community-based services under the 1983 initiated Community Care Program for the Elderly and Disabled (CCPED). Because of New Jersey Department of Human Services set limits, the population receiving long-term care through this program has remained small. CCPED, through its current existence (from 1983 through 1987) has provided home and community-based services for only about 5,000 people who would have otherwise entered a nursing home. Expenditures for those recipients in 1987 came to about $11.7 million.

State policy has developed through accretion, incorporating the complementary approaches of continued, albeit gradual, expansion of noninstitutional care and cost containment for existing care. In proceeding incrementally, New Jersey State Government has neither curtailed the sharp annual increases in Medicaid expenditures for nursing home care nor widened coverage for New Jersey's elderly enough to have a significant impact in meeting home and community-based care needs. While there is merit to the State's cautionary approach, particularly given the potential pitfalls of large-scale replacement of informal, and, therefore, not funded, provision of long-term care with publicly financed services, there are structural defects in existing approaches and serious elderly long-term care problems in need of address.

The central task that New Jersey Government has before it is to lay the foundation for a system that would meet the elderly's long-term care needs, yet not appreciably drain New Jersey's revenue base. To some extent the ground has been cultivated by governmental support the past few years for long-term care services such as respite care, home health services, medical transportation, chore services, medical and social day care, and homemaker services. However, these initiatives have occurred devoid of a comprehensive framework that would fully integrate these services and give overall coherency to the provision of long-term care, and reduce over-utilization of medically-intensive long-term care services. Given these shortcomings, it is important for the State to act, both for the sake of the elderly who, given the absence of these vital services, eke out their remaining years in misery, and in order to achieve cost-efficiency in the provision of existing and future long-term care services.

Thus, the Commission recommends that the State of New Jersey encourage more balanced utilization of the full continuum of long-term care services. Foremost, this entails relying less on nursing home care and fostering the expansion of residential health care facilities and home and community- based services. Such a shift would accomplish the dual objective of meeting elderly desires to retain their independence and also providing long-term care more efficiently by substituting less expensive services for high

cost institutional care when it is deemed appropriate. This overall objective has received near unanimous support, having been publicly espoused by New Jersey State agencies and task forces as well as national experts on the subject.[2]

Recommendation I: New Jersey should establish a more cost-efficient system of long-term care by encouraging the establishment of a greater number of lower level care facilities, and of community and home-based long-term care services.

Two major interrelated purposes underlie the objective of extending the continuum of long-term care services:

1) ***The substitution of less intensive long-term care, where appropriate, for numbers of the elderly receiving institutional long-term care,***

2) ***The expansion of community-based and home provided long-term care for seniors whose financial situation makes it impossible for them to pay for such services.***

Both efforts should take place in a context where movement toward greater public funding of community-based and home-based long-term care does not replace private care-giving. Encouragement of non-institutionalized long-term care should have the following salutory results: 1) it should limit premature institutionalization, 2) it should reduce the use of hospital inpatient stays, and 3) it should reduce the number of doctor visits. As illustration of the problem, the majority of the people awaiting placement in a nursing home facility in 1985 were in hospitals, exceeding the medically necessary length of stay. Given the exorbitant per diem costs of hospital stay, adequate and prompt placement at the appropriate long-term care level would achieve great cost-efficiency.

Important qualifications need to be noted—any future extensions of long-term care provision should rest on certification of physical and medical need, income eligibility, and unavailability of personal providers. The Community Care Program for the Elderly and Disabled (CCPED) serves as a model for doing all of the above. These constraints should serve to circumscribe the program's financial growth.

In developing a comprehensive program of long-term care, it is necessary to differentiate two kinds of efforts. One effort entails fastening together a comprehensive gate-keeping and case management system with jurisdiction

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[2]At least as far back as 1983, the New Jersey Department of Human Services, in a position paper, called for the establishment of a "full continuum-of-care" services. See *Expansion of Home and Community-Based Services For The Elderly and Disabled: An Agenda For Reform of New Jersey's Long-Term Care System* (Trenton, New Jersey Department of Human Services, September 1983). Recently the New Jersey Task Force on Catastrophic and Long-Term Health Care, in its report *Toward A Strategy For Long-Term Care Financing and Service Delivery* (December 1987), also called for the development of alternatives to institutional long-term care. At the national level, the National Conference of State Legislatures, in its 1987 report *Long-Term Care For the Elderly*, similarly recommended the development of a continuum of long-term care services.

over determining the proper level of placement for individuals in the long-term care system who are presently institutionalized or awaiting provision of long-term care services. The rudiments of such a system are in place in the State's Medicaid program. Whatever the directions of administrative development at the county level, the planning and data-gathering functions should remain at the State level.

Regarding the second effort, which is a long term goal, we recommend that State Government continue to expand the income ceiling for non-institutionalized, long-term care eligibility to include the near-poor—those living above the poverty line with limited income and financial resources. Such individuals face economic hardship and are incapable of sustaining the financial costs of long-term care services.

Institutional Arrangements for Extending the System of Long-Term Care

If extension of long-term care services is to be achieved in a comprehensive and cost-effective manner, institutional mechanisms are necessary to ensure that the needy elderly are afforded the appropriate level of care. Achievement of this objective entails matching the individual with the most appropriate level of service. This, in turn, entails the use of *case management* and *pre-admission screening* to process the elderly applicants of long-term care services.

In using these two processes as the basis for placement into a particular level of care, the present tendencies toward haphazard and inappropriate placement would be circumscribed. To achieve a coherent and well integrated system of long-term care, it will be necessary to unify the divergent funding and independently operated long-term care programs into a single administrative program. Administrative involvement must also entail full coordination among agencies so that duplicative and unnecessary provision of services are minimized.

Recommendation II: The Commission recommends the establishment of a central county-based administrative process for realizing appropriate placement in the continuum of long-term care.

The pivotal role of case management would be performed at the county level. In each county a particular entity would be designated the case manager for the service delivery of long-term care. Appropriate funding for administrative costs for case management should be provided by the State. The most logical choices for this responsibility are the county welfare agency, the county office on aging or the local Medicaid office. Other possible choices for this responsibility include county health departments, private hospitals or private non-profit agencies. The major responsibility would consist of medically-screening and processing the eligible elderly into the appropriate level of long-term care. In essence, the county based institution would be responsible for ensuring that the needs of the elderly person are matched by the provision of the appropriate level of care. In doing so, the case

manager, through the determination of physicians and hospital staff, would, in numbers of cases, be placing individuals in lower levels of care than is presently the case and thus making the provision of long-term care more cost-efficient. In addition, it would enable the elderly to live out their lives as independently as is possible.

In addition to the processing of individuals for long-term care, a designated county-based agency should be responsible for ensuring the integration and comprehensive availability of long-term care services. To a large extent this latter function would initially entail encouraging the extension of the service-delivery system toward greater availability of lower level care facilities, and community-based and home-based long-term care services. This would be accomplished by redirecting larger numbers of long-term care recipients toward greater usage of lower level care facilities and community and long-term care services. We recommend that State, county, municipal and private institutions do everything they can to further develop lower level care facilities and community-based and home long-term care services. The overall goal is to ensure that each elderly recipient receives the appropriate level of long-term care.

The financing mechanism should constitute the major vehicle for accomplishing this purpose. With pre-screening admissions determining eligibility and the needed level of care, the designated county-based agency would ensure that placement and the array of services provided is consistent with the needed care by overseeing clientele placement. County-based agency approval on placement would be required in order for State Government and county reimbursement to be forthcoming.

State Role in Long-Term Care for Those Financially Solvent

The State also should play a role in aiding the financially solvent elderly. It should be remembered that over 40 percent of elderly out-of-pocket medical expenses are for nursing home care. For many a middle class senior citizen, long-term care expenditures have meant subsequent impoverishment—the rapid diminishment of a lifetime of savings. However, here the State role should be regulatory and that of an intermediary.

State policy toward the financially secure should be directed at encouraging the establishment of insurance mechanisms that involve risk-pooling. Action in this regard can take place at several different levels.

Recommendation III: New Jersey Government encourage the establishment of long-term care insurance coverage for its employees as part of their retirement package.

One approach would entail a State measure in which State employees would be provided with long-term care insurance coverage for their retirement years as one of the options in their menu of health care coverage. It should be noted that the Department of Human Services is presently examining such a measure. Such a plan would be modeled after that of Social Security, with State employees' wage deductions a major contributor to funding the State

plan. State action in this regard would be beneficial on several scores. Given the substantial population base of the State Government work force, it would provide the opportunity for large-scale risk-pooling, thus providing a stable financial base and economies of scale that would minimize financial costs. For State employees, it would provide a worthy addition in coverage at a low cost, in addition to which, State Government would be relieved of incurring long-term care expenditures for a sizeable population group when they age. Finally, the development of such health coverage by the State would represent a major breakthrough, and thus serve as a model in encouraging associations or corporations with substantial employees to follow suit.

Recommendation IV: New Jersey State and local Government should encourage corporations to establish post-retirement long-term coverage for their employees.

A second approach entails encouragement of corporations to offer post-retirement long-term care coverage as part of their health insurance options for their employees. The State and county role would be to acquaint the corporate community with the advantages of having such coverage as part of their health care package.

Recommendation V: New Jersey Government encourage a non-profit association role in establishing voluntary long-term care insurance coverage for the general population.

A third measure would authorize the State to work with a broad non-profit group, such as the New Jersey Association of Retired Persons or the State AFL-CIO, to establish an insurance program, voluntary in nature and operated by the non-profit association, that would provide long-term care coverage for both retired persons and working people who subscribe to the insurance policy. Any forthcoming insurance plan for long-term care should be established as a nongovernmental program, although the State could provide budgetary expertise and possibly some financial backing in helping lay the foundation for such a program. For State Government, the endeavor should be viewed as a demonstration project that would determine the viability of large-scale provision of long-term care under risk pooling. By having State involvement, the likelihood of Federal and foundation grant funding to initiate such an endeavor would be increased.

The insurance proposals involving long-term care coverage for the non-indigent entail risk-pooling outside the established network of proprietary insurance companies. There are several reasons why we seek to encourage this route. First, insurance companies have proceeded extremely cautiously in entering in this area of health coverage and the costs and benefits, as of this date, have not constituted an attractive package for potential clients. One needs to add to this that a program with a large base of policy holders, rather than a splintered field of providers, would be more likely to achieve the economies of scale and clout over service-providers that most effectively keep costs in check.

Recommendation VI: New Jersey State and local Government encourage the corporate sector to make available adult day care for the parents of their employees.

Another worthy endeavor would be to encourage corporations to make available adult day care to employees who have chronically ill or infirm parents in the same way that some corporations provide nursery care. This can be done either by developing their own programs or contracting out with existing centers. Effort in this direction would alleviate a great mental and physical burden on the effected employees, and thus would make them more productive employees.

Service Credit for Volunteer Long-Term Care

In addition to sponsoring the expansion of long-term care services and the encouragement of insurance initiatives for those elderly that are not financially-strapped, there is a need for approaches that rely on the participation of the effected individual.

Recommendation VII: The Commission recommends that the elderly be afforded the opportunity to provide volunteer long-term care for future service credit.

Under such a system, the elderly would provide long-term care under the auspices of certified institutions with the formal understanding that senior citizens would be accumulating service credits for themselves and their spouses if they should ever need long-term care services. Such a credit exchange program is beneficial in two respects. First, it enables healthy senior citizens to provide a vital service for which there are personnel needs. Second, it enables those elderly who are not financially secure to accumulate service usage based on their labor rather than their financial resources.

Adoption of this measure, which has been supported by the Commissioner of Health, and is currently being developed by the Department of Human Services, in addition to securing greater long-term care assistance for senior citizens without additional government funding, would create reciprocity in the long-term care system. Senior citizens would be providing present-day long-term care services in return for future need. The credits accumulated could also be transferred in time of need to a spouse. We recommend that the Office on Aging be given responsibility for overseeing and promoting this program.

ADEQUATE HOUSING FOR THE ELDERLY

Adequate housing is another major area of senior citizen need. With the Federal Government's diminishing involvement in subsidized public housing, the problem of housing for the low-income elderly has intensified. Though the problem of housing for the indigent elderly needs to be addressed, it should be done in the context of meeting the overall housing needs of the low-income population. This entails a major Federal-State collaborative effort. In the interim, limited action, producing some redress, is possible. For a stratum of the elderly, income diminishment after retirement weakens their financial capacity to retain adequate housing. There are several measures which government can undertake to ameliorate the housing situation.

Home-Equity Conversion

Recommendation VIII: New Jersey should provide the regulatory framework and the public educational support that would enable the private sector to popularize the use of home equity conversion plans.

Many elderly find themselves in serious financial difficulty, despite having built up great equity in their mortgage-free homes. One of the answers, for senior citizens who are financially strapped, is *home-equity conversion* —the use of the equity in one's home to generate income without having to vacate one's property. There are two major options available. One, "reverse annuity mortgages," enables homeowners to take out loans against the value of their property for a set number of years at a fixed interest rate, at the end of which time the homeowner must repay the loan or sell the home to pay off the loan. A second format, the "sale-lease back plan," entails the homeowner selling his home, but as part of the arrangement the seller can lease back the home for the rest of his life. Usually, the seller receives a sizeable lump sum payment at settlement and regular monthly payments that exceed his rental cost. The purchaser is usually responsible for all house maintenance costs. Also, the home purchaser is responsible for paying property taxes, any major repairs and home insurance.

While experts agree home equity conversion has tremendous potential, its use remains rather limited. As the New Jersey Department of Community Affairs' *Task Force on Housing Options for Senior Citizens* recently noted: the hurdles against use of home equity conversion require public education and consumer protection on the part of New Jersey Government. Only when the State's senior citizens are familiar with this option and comfortable with its viability will home equity conversion increase in usage. *We concur with the Task Force that the Division on Aging be given the responsibility for the public educational role for home equity conversion and that the Division of Consumer Affairs and the Department of Banking develop regulatory guidelines under which the private sector can proceed with their home equity conversion plans.*

Exchange Programs

Another approach entails house cohabitation by matching people owning a house with those in need of housing. Fundamentally, this approach is directed at fulfilling the housing needs of single elderly persons, who have limited income, while at the same time providing the opportunity for integration into a social setting. It is also based on the effort to utilize existing housing more fully rather than expand the housing stock.

Recommendation IX: The Commission recommends public encouragement of two kinds of efforts. One entails establishing a "housekeeper program." The other entails encouragement of the existing "home-sharing program."

Housekeeper-Exchange Program

The *housekeeper-exchange program* involves voluntary agreement between an elderly person, slightly around or above retirement age, and a family to provide room and board for the individual in return for the ongoing performance of agreed upon household chores. These can include serving as a nanny for the children, dusting and cleaning, meal preparation, and gardening chores. The program rests on a mutuality of interest between the present-day, financially successful family and single elderly persons, particularly widowed elderly women, of limited income.

This program has the potential to fill a void in the social structure of the presently constituted upperwardly-mobile family in which both husband and wife are breadwinners. For financially successful families, this arrangement would provide someone to look after the children and/or tend to various household chores. For upwardly mobile couples faced with the possibility of nursery care, the housekeeper program, with its more personal touch, can serve as a useful alternative. For a single elderly person entering into this arrangement, there is the security of having room and board provided for and a social group to belong. Given the present demographics of the elderly population, in which women outlive men under conditions of financial insolvency, this program has the capability to contribute to a solution of this problem.

- **Home-Sharing Program**

The Commission also recommends stronger effort to expand use of the *home-sharing* program. This initiative, which is in use in several counties, seeks to match elderly homeowners, in need of additional income and/or companionship, with an individual, elderly or otherwise, seeking housing of modest rental expenses. Again, there is mutuality of benefit in utilization of this program, with minor use of public monies to advance the placement of senior citizens in adequate housing. We recommend a strong informational campaign be undertaken to present this program to the public.

The administration of both programs can be carried out at the county level with the county Office on Aging serving as the intermediary between homeowners and resident applicants. This is presently the format for those counties operating the home-sharing program. Program responsibilities would include bringing interested parties together, informing them of the reciprocal obligations entailed in the particular homeowner-resident relationship, helping them determine if they are compatible, establishing a trial period to test their compatibility, and helping them draw up a formal agreement that would define the obligations in the relationship.

- **Accessory Dwelling Units**

Another promising approach that would ameliorate the housing situation of the frail elderly is house conversion. By partially modifying the structure of a house, the elderly can live with their grown children under conditions of semi-independence. Municipalities thus can aid senior citizens by broadening the zoning ordinances to allow an "accessory apartment" for elderly relatives within single-family homes. "Accessory dwelling units" entail the

alteration of a section of a single family home by converting existing dwelling space into a bathroom and/or a kitchen. Where they exist, municipal zoning ordinances, allowing "accessory dwelling units," are drafted to be conditional in nature, expiring with any change in the living arrangement between the elderly occupant and the homeowners. Such measures allows seniors to reside with their grown children, and receive the custodial help they need, while at the same time retaining a measure of independence.

In making the living arrangement conditional, the fear of neighborhood residents that their community gradually will be turned into an area of tenant occupied homes may be allayed. Several stipulations are common to municipalities adopting "accessory apartment" ordinances: the owner must occupy the property; with the exception of an additional entrance, the exterior of the house cannot be changed; one must apply for the conditional use and obtain the approval of the planning board; the property must have a minimum square footage; the senior occupant must be a direct relative of the homeowner; and additional provisions to accommodate the senior relative, such as an extra parking space or a disposal unit on the property, must be made available. Other provisions worthy of consideration, that are intended to retain the character of a neighborhood, include: the requirement of an annual affidavit of continued compliance with the terms of the accessory housing ordinance by the owner of the dwelling; and the requirement that the building inspector conduct ongoing inspections to ensure compliance. Among the municipalities in New Jersey which have a zoning ordinance allowing "accessory dwelling units" are Lafayette Township, Stillwater Township, Passaic Township, Metuchen Borough, Princeton Borough, and Old Tappan Borough.

Relief for Elderly Low-Income Homeowners

There are many elderly who own their own homes yet find themselves in precarious financial straits. One of the major objectives of government should be to provide support so that they can continue to remain in their homes. Various programs for the elderly presently provide such assistance. Further governmental efforts should be forthcoming to strengthen the elderly's ability to remain in their homes.

- **Home Repair Program**

For present elderly homeowners, that have low-incomes, the Commission recommends an expansion of the existing "home repair program." The home repair program which is operated by several county Offices on Aging, has been an important resource for elderly homeowners of limited financial means whose dwelling is in disrepair. We suggest that high school vocational students, specializing in building construction, as part of their advanced training, participate in the home repair program.

Recommendation X: The home repair program for low-income elderly homeowners be extended to include assistance through high school vocational student projects.

This would give these students practical experience, while at the same

time improving the living conditions of limited income elderly homeowners. Elderly homeowners, who are to be recipients of the program, would have to be certified as having low incomes.

JOB PLACEMENT FOR SENIOR CITIZENS

With senior citizens living longer and enjoying better health than previous generations of the elderly, there is a need to reconsider the sharp differentiation in the work situation between citizens under 65 of age and those over the age of 65. Given the financial plight of many elderly, there is a desire on their part to supplement their income. For other citizens, there is a large void in life that results from the shift of having a full-time position to a nonworking situation.

These personal considerations also are consistent with the changing demographic and economic realities of New Jersey. With an expanding elderly population, greater pressures are placed on New Jersey's revenue base to provide greater senior citizen services. As the percentage of New Jersey's population that is working declines, the financial pressures on the working population, as the support group, increases. Furthermore, economic projections point to future employee shortages in the expanding service industry and high-tech sectors.

Given these psychological, economic, and social dimensions, ***there is a growing need to provide additional job placement programs for senior citizens.*** The emphasis of the program would be on part-time work, although effort would also be made to place those seeking full-time employment. Unlike the existing *Title V* of the Older Americans Act program, with its orientation toward those of low-income and toward placement in government and nonprofit organization jobs, the emphasis would be on private sector placement, with all senior citizens eligible to participate in being placed.

> ***Recommendation XI: County governments should be encouraged to develop job placement programs for senior citizens above the poverty level. The emphasis should be on placement in the private sector.***

The primary role of the program would be to bring together private employers and interested seniors in filling available positions. These positions can be part-time, temporary, or even full-time. In fulfilling this responsibility, basic training sessions on items such as preparing a resume, job interviewing, and upgrading one's technical skills in areas such as familiarity with the computer and performance of clerical tasks, also could be made available.

Given the objectives of this program, the locus of program activities and responsibilities should be at the county level. In making this recommendation, we were struck by the *Project Resources Program*, operated by Middlesex Community College, and view it as a model for other counties. However, it would be administratively more rational and cost-efficient to place the program within the office operating the *Title V*—Older Americans Act employment program (with the *Title V* program retaining its separate features and identity). In making this recommendation, we view this administrative format as the most desirable, but concede that, when such a program is instituted,

county government should place this program in the office it chooses. Also it is desirable to loosen *Title V* restrictions so that the near-poor elderly would be available for job placement and so that the County Offices on Aging could devote placement efforts to the private sector.

Adoption of this recommendation should produce several salutory effects. The financial viability and psychic state of numbers of New Jersey elderly residents would be improved. Placements of greater numbers of seniors in positions would further stimulate New Jersey's economy. In addition, by generating additional income for the elderly and making the elderly more financially independent, this program would be beneficial budget wise for governments within New Jersey.

ABOUT THE COMMISSION

The New Jersey Legislature established the County and Municipal Government Study Commission with the charge to "study the structure and functions of county and municipal government ... and to determine their applicability in meeting the present and future needs of the State and its political subdivisions."

To achieve as broad a representation as possible in carrying out this legislative charge, a Commission of fifteen members was created, nine of whom are named by the governor, three of whom are senators, named by the president of the senate, and three of whom are assemblymen, named by the speaker of the general assembly. Of the governor's appointments, three are nominees of the New Jersey Association of Counties, three are nominees of the New Jersey State League of Municipalities, and three are from among the citizens of the State.

The Commission's initial report, *Creative Localism: A Prospectus*, recommended a comprehensive and systematic study of the patterns of planning, financing, and performing functions of government. This assessment seeks to develop more effective approaches for service provision among municipal, county, and state governments through statutory amendments and changes in administrative practices and policies.

In light of these goals, the Commission has examined alternative forms of service provision on a larger-than-municipal scale and evaluated current systems for provision of services. This research has led to a series of structural studies dealing with county government, joint services, consolidation, and municipal government forms. The Commission also engages in functional studies that are focused upon the services that local governments provide or should so provide. These functional studies have included examinations of transportation, housing, social services, health, solid waste management, flood control, libraries, and state mandates. In addition, a series of informational periodicals and handbooks are published for the use of officials, administrators, and others interested in New Jersey government.

While the Commission's research efforts are primarily directed toward continuing structural and functional studies, its staff is often asked to assist in the drafting of legislation and regulatory action based upon Commission recommendations. The Commission also serves as a general resource to the legislature, executive agencies, local government officials, and civic organizations, as well as to related activities at the national level.

PAST REPORTS OF THE COUNTY AND MUNICIPAL GOVERNMENT STUDY COMMISSION

The Organization and Dynamics of Social Services in New Jersey, June 1979
Forms of Municipal Government in New Jersey, January 1979 (In cooperation with the Bureau of Government Research, Rutgers, The State University of New Jersey)
*Local Highway and Road Programs: The Capacity of Federal and State Aid Programs to Meet Increasing Needs, September 1978
Computer Utilization by Local Government, November 1977
*Flood Control Management: An Overview of Issues and Responses, November 1977
*Bus Transportation: State-Local Roles and Responsibilities, May 1977
*Aspects of Law Enforcement in New Jersey, June 1976
*Water Supply Management in New Jersey: Summary of Findings, April 1975
Community Health Services: Existing Patterns, Emerging Trends, November 1974
*Housing and Suburbs: Fiscal and Social Impact on Multifamily Development, October 1974
*Water Quality Management: New Jersey's Vanishing Options, June 1973
Solid Waste: A Coordinated Approach, September 1972
A Public Personnel Information System for New Jersey, March 1972 (In cooperation with the Bureau of Government Research, Rutgers, The State University of New Jersey)
*Consolidation: Prospects and Problems, February 1972
*Beyond Local Resources: Federal/State Aid & the Local Fiscal Crisis, April 1971
*Joint Services: A Practical Guide to Reaching Joint Services Agreements, May 1971 (In cooperation with the N.J. Department of Community Affairs)
*Joint Services: A Local Response to Area-Wide Problems, September 1970
County Government: Challenge and Change, April 1969
Creative Localism: A Prospectus, March 1968

*Available upon request