Creating Communities of Place

SENIOR HOUSING AND SERVICES: ECONOMIC, DEMOGRAPHIC AND POLICY ISSUES AND THEIR LAND USE IMPACTS

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SENIOR HOUISNG AND SERVICES: ECONOMIC, DEMOGRAPHIC AND POLICY ISSUES AND THEIR LAND USE IMPACTS

A Literature Review and Issue Paper
for
The New Jersey Office of State Planning

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by
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PREFACE

Why Study Seniors and Land Use

New Jersey's growing senior citizen population will have an enormous impact on the state's land uses. Senior housing, health and social service facilities, and transportation services are just a few of the more obvious uses that, if built to meet demand, will multiply, undergo changes in design, and/or develop in new locations. This report is the first part of a three part research project that aims to help state and local policy makers and planners in New Jersey to formulate strategies that will address the rapid expansion of the state's senior population over the next 35 years.[1] The research will seek to answer land use questions as they relate to housing-based demographic imperatives. These questions are: (1) What might be the land use impacts of the growing senior population in New Jersey?; (2) How will senior population trends affect New Jersey's different communities?; (3) How do these trends relate to the goals embodied in The New Jersey State Development and Redevelopment Plan (SDRP)?; (4) How can the SDRP be further refined to address aging trends?; and, (5) What sorts of research outcomes will assist state and local policy makers in crafting responsive policies?

Predicting the nature and extent of long-term senior housing-related land use demands is difficult and necessitates an understanding of: (1) factors that most strongly influence the housing decisions of seniors; (2) demographic trends in the senior population and relationships between seniors and other age groups; and (3) public policies that affect senior housing and services. This report, Part 1 of a 3 part study, reviews the available literature and data and highlights trends that have influenced or may influence future senior housing decisions. The report consists of 4 sections. Sections I through III define the parameters within which seniors make housing decisions and the patterns of those decisions in recent years. The first section identifies the most important factors in senior housing decisions. The second section reviews senior residential preferences and migration patterns. Section III describes the various senior housing forms and, to the extent possible, enumerates New Jersey's supply of each type. Section IV examines the impact of public policies and financing issues on senior housing and services. The Executive Summary highlights the findings, and where appropriate, suggests the implications of each for land use in New Jersey. The report also suggests guidelines for Parts 2 and 3 of the larger study. The report uses the term seniors to refer to persons age 65 and over. Where information is relevant and available, it is also furnished for persons aged 60 plus, 55 plus, and for several senior subgroups.

[1] Most of the literature on seniors and senior housing describes and quantifies the senior population, its subgroups, and their housing problems, such as financing, accessibility, service needs and structural modifications. Scant research, however, is available that analyzes these issues thoroughly as they relate to land use, except for some studies of senior migration and associated economic impacts. The paucity of this sort of research makes the Office of State Planning's efforts to explore land use impacts of an aging population all the more necessary.

EXECUTIVE SUMMARY

The Roots of Senior Housing Decisions

- Seniors evaluate various housing alternatives in the context of available and needed services and their economic resources.

- In order of importance, economic resources, the presence of disability, and the availability of appropriate community, personal, and health care services are the three most important factors in senior housing decisions. Also, health status, not disability, determines whether seniors enter long-term care institutions such as nursing homes.

Economic Resources

- The economic resources of all age households will determine the ability of these households to make basic housing and service decisions. Careful demographic analysis of the present and future economic resources of different population groups is required to anticipate the future housing patterns for these groups.

- Senior net worth, or the value of all economic resources, varies widely for different senior subgroups. Net worth for almost all senior subgroups increased in the 1980s at the same time that the net worth of younger groups declined.

- Generation-specific long term decline in net worth suggests that tomorrow's seniors will have far fewer resources available for housing and services. Disparities in the net worth of different age groups, however, must be viewed with caution.

- Although today's seniors are relatively well off compared to other groups, as seniors age, their resources for housing and other basic expenses rapidly dwindle.

- Not surprisingly, households headed by the college-educated and men, or households that were married-couple or young senior households, were better off than other subgroups. The poorest senior households were headed by women, the widowed, and those with less than a high school education.

- The sources of net worth for different senior groups varied considerably in the 1980s. Much wealth was invested in the less fluid assets. Almost all groups invested considerable resources into home equity.

- Over 90 percent of all seniors collect social security income, and over two-thirds earn interest income. The median social security income declined as people aged and interest income earned by seniors was low.

- About 45 percent of younger senior households collected pension income in 1991, but this dropped to slightly over one quarter for the older senior groups. Pensions are anticipated to be a larger source of retirement income for tomorrow's seniors, especially for women.

- Wages and salaries were the source of the highest median income for each age group when compared to other sources. Employment trends suggest that the percentage of senior households receiving wage and salary income will increase in the future.

- Although a high percentage of seniors are poor, few seniors receive public assistance or disability income. Several characteristics of disability income make the prediction of future benefit levels difficult.

- Considerable controversy surrounds the future solvency of the social security system. Inter-generational tensions over the distribution of entitlements, demographic imperatives under which fewer future workers will support more future retirees, and criticism of congressional budgetary techniques, have lead some to believe that social security insolvency will occur by 2030. Restructuring of the labor force and the use of new retirement investment tools have lead others to dismiss claims of such a crisis. Since social security is a large portion of income for a large proportion of seniors, the state of the social security system will have significant impact on housing resources.

- Steady advances in the level of educational attainment, rising rates of senior employment and longer work lives of women lend credence to predictions of higher future senior incomes. Declining real wages and salaries, and higher proportions of single-person and minority-headed households, on the other hand, may erase these gains. These trends will affect the ability of tomorrow's senior households to purchase available housing and will shape demand for particular sized housing units.

- An analysis of demographic trends in New Jersey's population, at the municipality level is required to evaluate present and future patterns of housing use that will result in community-specific senior land use impacts. This analysis should include the following factors: age; sex; race; martial status; offspring; life expectancy; household size; health and disability; employment; net worth; wage and salary, pension, social security, disability, and interest income; and home equity.

Housing Costs

- Future senior land use patterns will be shaped first and foremost by the geographic locations of senior's homes. Since economic resources have the greatest influence on senior housing decisions, the ability of tomorrow's seniors to choose among various housing options will also depend on housing costs.

- New Jersey's high housing costs, coupled with the relative land and housing values across different communities, limit the housing options available to seniors. For example, seniors may not be able to move by swapping their housing equity for smaller units and reduced maintenance costs.

- As a group, today's seniors have had fewer problems securing affordable, safe, and adequate housing than have other groups, in part, because of income growth in the past relative to housing costs, and associated tax policies. As a result, home ownership is

high among today's seniors. At the same time, however, many seniors are overburdened by the cost of housing.

- As seniors age, rising housing costs relative to declining incomes will make housing less affordable. Moreover, if present trends continue, tomorrow's seniors may have far fewer assets and lower incomes compared to housing costs. These demographic trends could effect the entire housing market since trades, sales, and equity swaps in one market segment depend, in part, on the nature of transactions in other segments.

- Many of the substandard senior housing units are simply older structures. But also, poor quality housing and senior poverty are associated nationally with the high costs of local taxes and home maintenance, waning government housing assistance programs, and a shrinking supply of rental housing stock. All of these trends are present in New Jersey. More research is required to determine to what extent, if any, future seniors will only be able to afford substandard housing, where these units will be located, and why.

Disabilities

- After economic resources (as they relate to costs), the presence and severity of disabilities is the most influential factor in senior housing decisions.

- Cultural advances, legislation, new technologies, and design changes in community facilities and infrastructure have improved the quality of life for disabled persons. These trends have created more accessible communities, enabled more seniors to age in place and enjoy richer lives, and may have reduced the costs of personal services and premature institutionalization. These trends are expected to benefit future seniors even more and, to some extent, partially reduce the growing need for long-term care facilities.

- Trends suggest that future intergovernmental funding for facilities and infrastructure development will be tied more closely to well documented needs assessments of disabled persons and improvements in their community functioning. Unfortunately, few states have adequate assessment methods or resources. More research is required to evaluate the strengths and weaknesses of New Jersey's assessment methods. However, if these methods are found to be lacking, this is an area around which the Office of State Planning and other state agencies could easily collaborate to improve and create more uniform models, share data, and make results more useful for and easily available to the state's communities and organizations. This may also be possible for all age-related demographic analysis conducted by the Office of State Planning.

- Although disability rates will help us ascertain in what kind of facilities and units some seniors will choose to live, it is important to keep in mind that over three-quarters of all seniors have no disabilities and over half of those age 85 and over are disability-free. These seniors are less constrained by functional concerns in their housing decisions.

- Nonetheless, 20 percent of seniors have at least 1 disability which impairs their ability to carry out an activity of daily living (ADL). Also, disability rates are higher for older

senior groups. Almost 40 percent of men and 48 percent of women over age 75 had at least 1 disability.

- Some senior subgroups are more likely to experience disability than are others. Also, disability rates, have not changed dramatically overall, but have changed for certain groups. As the proportion of disability-prone householders increase, higher numbers of disabled seniors are expected in the future. On the other hand, increasing levels of education, may serve as a counter weight to these increases. Also, some health care and service trends suggest future reductions in disability rates. Disability-linked variables should be accounted for in senior population projection models and related demand forecasts for various housing types.

- The numbers of frail seniors will rise rapidly in the 1990s. These seniors tend to have high unmet housing and service needs. Frail seniors will increase the demand for supportive housing environments in the 1990s and through the 2020s.

- Although home modifications can help disabled seniors live more independently, or, at the least, improve the quality of their lives, relatively few seniors make these modifications. These findings have immediate public policy implications.

- Despite technology advances that have opened communities to many disabled adults and children, equipment and home modifications have enabled only a small proportion of disabled seniors to function independently. Future increases in the number of disabled seniors confined to the home could increase the demand for an array of service personnel. If sufficient economic resources are available to pay for these services, and, substantially more workers enter these fields, then many more workers could be working in homes. This may have commutation and parking impacts for communities with increasing numbers of seniors.

- Risk factors explain only 20 percent of the variability in long-term care facility admission rates. Some characteristics only influence the timing of institutionalization. Economic and social resources explain housing arrangements and the likelihood of housing problems, but not institutionalization. With additional research, these factors can be incorporated into Office of State Planning's demographic projection models to project future long-term facility needs and their locations.

- While only 5 percent of seniors live in institutions, from 25 to 45 percent of all seniors will be institutionalized at least once for a period of less than 1 year. Because of the dramatic growth in the senior population, both permanent and shorter-term institutionalization will increase the demand for long-term care beds. More research is required to determine how many of these facilities will be needed in New Jersey, and where and how large they will be, and their related employment, commutation, and local infrastructure impacts.

Solutions to Senior Housing and Services Problems

- In the last decade, experts have advocated merging senior housing and services to help seniors age in place and resolve many senior housing and service problems. Also, this seems to be the form of senior housing most needed and least available now and for the future. Experts contend that facilities with skilled service coordinators who can provide somewhat individualized service packages, yet achieve economies of scale in service delivery, and use community-based and voluntary service providers will be the most successful. This model could be achieved by multiple smaller facilities located in the same community and owned and/or operated by the same service coordinator and vendors or by larger facilities, each with different land use impacts.

- Some experts argue that adding large numbers of these facilities is the only practical approach to meet growing senior housing and service needs. They contend that these facilities should be located near already existing social, health, and recreational resources. Such an expansion would have uneven land use impacts on New Jersey's communities and requires additional research.

- The politics of early congregate housing and assisted living programs, such as the Congregate Housing with Services Programs, have shaped the number of projects and the services provided in them more so than have determinations of need.

- Many innovative solutions to senior housing and service programs have continued to be little more than demonstration projects for approximately a decade. Political, fiscal, practical, and cultural barriers have prevented their expansion. If large scale expansion of these programs occurs, the land use and other impacts could be greater concentration of housing development in already built communities, greater aging in place by seniors, possibly more affordable housing in some communities, and higher incomes for some seniors.

- Others contend that any analysis of alternative senior housing and service planning must consider the positive and negative impacts to other groups. For example, intensive construction of senior congregate housing could open up more affordable housing for younger households in many communities.

- The costs and benefits of building new congregate housing on a massive scale, however, will be difficult to demonstrate and such expansion has little political support today. In fact, most senior housing financial incentives and programs have been cut in recent years. In New Jersey, at the same time that the senior population has swelled, the rate of senior housing construction has declined.

Residential Preferences

- The overwhelming majority of persons over age 55 want to remain living in their current home for the rest of their lives and a majority of them will do so. To the extent that they are able to remain where they are, the housing land use of this group will remain their housing land use for the next 5 to 25 years, depending on individual ages.

- Aging in place, rather than migration is the trend among seniors. This bodes well for goals within the New Jersey State Plan to use existing infrastructure and contain development within existing communities. The preference to age in place reduces potential development pressure for new structures. On the other hand, the growing demand for services and rising demands for service-assisted senior housing, which is in limited supply, may result in some seniors moving elsewhere.

- Today's seniors realize, more so than those of the past, that as they age they will need housing changes and new services. But few seniors plan for future housing needs.

- Few seniors use assistance programs to make housing decisions, to plan for future housing needs, or to make design changes to facilitate independent functioning. Scholars recommend a greater emphasis on low-interest loans, counseling, technical support, education and referral services, and community facilities and programs geared to crisis intervention since many seniors make such decisions only when disability strikes.

- Of seniors who believe they might move, over one third preferred a small town, one fourth preferred a suburb, one forth the countryside, and 13 percent desired central cities. Also, if forced to move, most prefer age-segregated buildings, but only 25 percent want age-segregated neighborhoods. Security, safety, parking, meals, and heavy housekeeping figure prominently in the housing preferences of seniors. In addition, relocating seniors prefer housing in neighborhoods that are in close proximity to particular facilities and services, such as grocery stores, pharmacies, doctor's offices, and hospitals.

Migration Trends

- Seniors tend to move at three points in life: retirement, the onset of mild disability, and at the onset of moderate and chronic disability. The characteristics of the destinations associated with each of these moves are different. Most seniors who move, however, remain in the same community, and secondly, in the same state. Communities with high percentages of seniors or future seniors in specific age subgroups can expect the related migrations.

- Interstate migration patterns of seniors remained stable over two decades, but more recent research is required to affirm the patterns of the 1980s and early 1990s. In general, seniors remain where they are. New Jersey seniors who moved out-of-state tended to move to Florida and North Carolina and then return to New Jersey when they were older, widowed, disabled, and/or poorer. Should these patterns continue, large reverse migrations may further tax available senior housing and service facilities, local and state budgets, and younger families.

- Rural disabled seniors without children tend to move to suburbs and central cities for the services. Rural areas with high concentrations of seniors may experience a decline in the percentage of the senior population, barring responsive policies and programs.

- Longer-term predictions of senior migration patterns are more difficult to make. Major industrial transformations, technological revolutions, and migration patterns of various racial and ethnic groups could generate unforeseen migratory behavior among all age groups, including seniors. Since most seniors hope to remain where they are living now, it is reasonable to believe that settled, middle-age households will probably remain where they are as they age. Communities with large stocks of good quality housing and without neighborhood deterioration might expect relative stability in their senior populations. Communities with large percentages of the population in the same age group may experience more out-migration as these groups mature and some seniors move at retirement.

- Because of the intergenerational dependency that operates in the housing market, coupled with uneven housing values in different communities, the housing impacts of shifting age groups will be even harder to predict for the long-term. For example, communities that anticipate large older senior populations in the future may have more housing open up to younger households assuming: (1) the prices of these units are affordable for these households, which might have far fewer resources than was true in the past; and (2) there are also service-assisted housing units in the community or nearby communities. Similarly, if demand for the homes of older seniors in some neighborhoods becomes insufficient due to skyrocketing prices or, alternately, neighborhood decline, seniors in these places may be forced to either remain in their homes and bear excessive housing cost burdens, or absorb large losses in their home equity in order to move to smaller, more manageable units. Any predictions of moves by older seniors assume service-assisted housing is available.

- Today's successes in containing sprawl in New Jersey may confine the areas of settlement by younger households to built-up communities. In turn, these communities could be the areas where these households age in place.

Housing and Services Supply

- As noted above, senior housing use is dependent upon the relative resources of senior households to housing costs, and to the housing use of other household groups. Detailed demographic analysis of different age, income, and types of households in the state, in the context of housing and service cost and availability studies, is required to more precisely discern present and future trends in housing and service supply.

- Most seniors are and most future seniors will be intermingled with the general population in single and multi-family housing units. Only a small percentage of the senior population lives in age-segregated housing. This, however, partly results from an insufficient supply.

- A confusing array of alternative senior housing forms have been developed in the last few decades. See pages 44 through 52.

- Retirement communities are expensive, are in over supply in the state, and are heavily concentrated in some counties. Long-term demand might escalate as the more affluent baby boomers retire, but housing preferences suggest this may not be the case. While age-segregated housing is preferred by more and more current seniors, age segregated neighborhoods and communities are not. And, these communities may be just too expensive compared to the cost of purchasing services from one's home as needed. Nonetheless, more complete analysis is needed of this niche market to forecast future demand more accurately.

- Present demand for continuing care retirement communities is also low as these communities have very high vacancy rates. Future demand should be carefully assessed, particularly because of the extensive land impacts these communities create. Multi-level facilities and residential health care facilities are older developments and dispersed throughout the state. More research is required to determine present and future demand of these facilities.

- Assisted living residences and congregate housing, particularly subsidized units, are the types of senior housing most needed in New Jersey. Affordable congregate housing, a form popular with seniors of a variety of socio-economic backgrounds, and assisted living residences are woefully inadequate. Cuts in public funding have limited efforts to increase the supply of this housing and it is not expected that there will be anywhere near the large number of facilities needed for the 1990s and 2000s based on current trends. What is more, waning political support and serious concern that these structures will become de facto institutions as their residents age and as developers try to achieve economies of scale by building large buildings, have put these housing forms in jeopardy for the long term. Thus, although it is possible, with more precise research to project the long-term need for senior housing in the state, predicting the long-term supply of subsidized facilities, barring specific revisions in public policy, will be far more difficult.

- Subsidized senior housing with and without services is severely undersupplied in New Jersey. Waiting lists vary from 6 months to 25 years in various locations, with a state average of nine years. Furthermore, the pace of development of these facilities in the state slowed drastically in the 1980s and is not expected to pick up in the near-term. The land use impacts are that seniors who need this form of housing are remaining where they are. There may also be inter-generational land use effects, but this requires further research for specificity.

- Housing innovations such as shared living residences, accessory apartments, and elder housing opportunities have been in New Jersey for many years on a small scale, but have not progressed much beyond the demonstration stage. These forms have many social, economic, and personal advantages for seniors, families, and communities. However, nationally, public opposition, municipal zoning laws, and county and state laws have limited the expansion of these alternative housing forms. Nonetheless, some local governments have undertaken measures to clarify their zoning ordinances and to address community concerns. These communities have been able to expand the supply

of housing options. More community-specific research is needed to determine why so few communities in New Jersey have these housing alternatives.

- Real estate developers and hotel industry managers who entered the senior housing market in the past decade did not foresee the costs of providing additional services to their new aging niche market and underestimated the demand for expensive retirement communities in some areas. Industry consolidation and risk avoidance have slowed down the development of the more up-scale projects.

- Additional research is required to determine if the supply of skilled nursing and intermediate care facilities is adequate for the state's present and future needs. If effective demand is known, these facilities have fairly predictable land use impacts in terms of footprints, employment and commutation, service requirements, and linkages.

- Detailed demographic studies could reveal the size of the eligible populations for each residential type in the state's communities. Since all facilities regulated by New Jersey's state agencies have minimum spatial requirements for unit sizes, services, and facilities, these projections can be transformed into future land use demands for various communities or counties.

Services Financing and Policies

- Services should be linked to senior housing studies, plans, programs, and projects. This is because service availability, in part, influences the housing and moving decisions made by seniors, particularly older, ill, and disabled ones.

- The separation of public agencies responsible for housing, health, and senior services, however, makes the logical merger of housing and service functions more difficult. While some demonstration projects exist or are being developed, inadequate public funding for senior housing and services limit the development of more supportive living environments.

- Community-based services, based on preliminary research, seem to be the best service option for seniors, their families, and for communities. Also, seniors who move select communities, in part, because of service availability. Unfortunately, community-based services have suffered from funding cuts, fragmentation in delivery systems, insufficient new entrants into service occupations, high costs, insurance company and government policies that favor large institution and nursing home care, health industry consolidation, and the uncertainties of cost containment and health care reform. Community-based services will have little impact on land use in the near future. The land use impacts of some of these trends mirror those of nursing home and large hospital development.

- Current spending patterns support the expansion of large medical service and research facilities. Thus, many communities incorporated health care facility development into their economic development strategies and these facilities have had considerable land use impacts for particular communities through structure expansion, employment

growth, commutation shifts, forward and backward linkages, and municipal infrastructure and service needs.

- Health care industry consolidation will further concentrate services, eliminate unprofitable community-service facilities, programs, and specific services. Health care reform may also affect the location of services, but, because of the chaos in health care reform efforts, these consequences are difficult to predict at the moment.

- Although the rates of institutionalization in skilled nursing and intermediate care facilities might be dropping, due to the vast increase in the senior population, we can expect a need for more of these facilities. At the same time, severe staff shortages in several medical and allied health professions suggest that these facilities will be strained, and possibly, few will be added in the immediate future. Industry-specific research is required to confirm these speculations and to calculate the land use impacts.

- For seniors and their families, the results of an insufficient supply of affordable senior services are premature institutionalization, family strain, greater transportation use and costs to locate needed services, or living without necessary services. More research is needed to analyze the availability and development trends of various types of senior services in specific communities and their related land use impacts.

Housing Finances and Policies

- Government subsidies for senior housing has been drastically reduced at the same time that the eligible population has grown. Also, tax reform legislation has removed many of the financial incentives available to developers of senior housing. Additionally, bankers have restricted credit and regulators have tightened controls for the new development of retirement communities. Shifting to other forms of financing has been more costly for many developers, limiting the financial rewards of building these projects. Needless to say, the construction of these projects has slowed.

- Some scholars and practitioners, recognizing the desire of seniors to age in place, have pushed for measures such as equity conversion programs to capitalize on income to equity imbalances. However, a multitude of variables such as tax laws, equity conversion rules, and state policies protecting home equity have meant unsatisfactory levels of interest and participation in equity conversion programs to increase senior disposable income.

- Many senior homeowners are estimated to possibly benefit from a variety of home equity conversion instruments developed in the 1980s, such as reverse mortgages, sale/leasebacks, split equity agreements, deferred payment loan programs, and tax deferral programs. Certain types of seniors have shown the most interest, yet program participants have very different characteristics.

- Interest in equity conversion programs has been much less than expected for many and diverse reasons. Recent research, however, suggests that with program revisions and better targeting, more seniors would use equity conversion. Large potential markets are

thought to exist in the suburbs and in the New York and Philadelphia Standard Metropolitan Statistical Areas. If these tools are used on a massive scale, more seniors might stay in their homes for longer periods, and seniors might have more expendable income for purchasing needed services, home maintenance, and home modifications. In turn, these housing stocks may be kept in better condition for future households, some neighborhoods might suffer less decay, and therefore be more attractive to new residents.

New Jersey Senior Services and Housing Programs

- The state has a broad array of senior housing and service programs administered by state, county, and local agencies. Most programs, however, suffer from underfunding and are unable to meet senior needs in the near-term. Further research is needed to assess the level of funding required to meet future senior housing and services needs and to discern state trends in funding with any specificity.

- Based on initial research, the inadequate supply of service-assisted housing must be addressed in such a way that: (1) new housing is added within existing communities; (2) new housing is located in or close to the communities in which seniors or near seniors live; (3) new housing is located near community resources such, as churches, health care and social service facilities, grocery stores, pharmacies, personal services (such as hair salons), restaurants, convenience stores, and recreational sites (such as walkways and senior centers).

Recommendations for Study Parts 2 and 3

- Part 2 of the Office of State Planning's study of the land use impacts of aging should focus upon New Jersey-specific research by: (1) conducting detailed demographic projections to identify precisely trends in population and household subgroups, their economic resources and their health and disability; (2) studying the employment, housing, and transit behavior of seniors and how these relate to land uses; (3) more clearly determining seniors use of, the costs of, and delivery, policy, and industry trends in specific services including personal services, such as housekeeping and home care, and health care, pharmacy, and some retail services; (4) more specifically analyzing the intergenerational relationships in senior entitlement income, employment, housing use, and family care and resultant land use impacts; and (5) examining housing markets, costs, and the demand for the various housing forms in different communities. For the greatest utility, these investigations should be conducted at the municipality level.

- In addition, interviews should now be conducted with informed experts, such: developers of alternative forms of senior housing; housing market and finance analysts and lenders; housing program administrators; aging experts; health and service industry analysts and administrators; entitlement program administrators and analysts; income and employment analysts; practitioners in municipalities with large senior populations or housing demonstration projects or age-inclusive zoning ordinances; transportation specialists; home builders and developers; designers of accessible housing; facilities; and infrastructure; and policy makers. Also, given the broad range

of topics covered in Part 1, some conclusions should be bolstered with additional research before being included in planning and policy proposals.

- Interagency collaboration through the state agencies and the state agency planners and program focus groups might be useful for: (1) selecting additional appropriate demographic variables for analysis and for incorporation into projections; (2) designing methods to assess alternative housing demand; and, possibly, (3) distributing data for intergovernmental use. Appropriate agencies and divisions include the NJDCA, NJDoA, NJDoHD, NJDoHS, NJDoH, NJDoL, NJSDC, and NJDoT. The usefulness of Part 2 product outcomes should be explored as a Office of State Planning Special Project.

- Preliminary and final results of Part 2 should be available for incorporation, as appropriate, into The NJDCA Comprehensive Master Plan, The Bicycle and Pedestrian Master Plan, MPO Long Range Transportation Plans, state human service and education plans, The Economic Master Plan, local area strategic revitalization plans, capacity-based master planning manuals, community facilities guidance documents, NJOSP employment, housing, infrastructure, and population submodel assumptions (or handles), and quality of life indices.

- Final results of Part 2 should be available to state and local agencies in easy-to-use formats.

- Part 3 research should lead primarily to a policy and planning document, based on the findings in Parts 1 and 2. In this document, direct planning implications of study results should be laid out in reference to the state and its centers and planning areas. Analysis should be made in the context of the statewide planning goals, strategies, and policies. Also, appropriate refinements should be recommended for inclusion in The State Development and Redevelopment Plan and NJOSP models.

SECTION I:

ECONOMIC RESOURCES, HEALTH AND DISABILITY STATUS, AND SENIOR HOUSING DECISIONS

Money and Independence: The Catalysts of Housing Decisions

When housing decisions must be made in later years, economic resources and health and disability are the driving forces behind the various arrangements chosen by seniors (see Mitchler and Burr 1991; Monk and Kaye 1991; Dolinsky 1988; Avery, et al. 1989; Golant 1992; Varady 1990). Not surprisingly, economic resources are the most important factor behind particular living arrangement choices (Mitchler and Burr 1991, 386). Economic resources are less important, however, to whether or not seniors enter institutions (Mitchler and Burr 1991, 386). Rather, health status most affects decisions about institutionalization of seniors. Moreover, particular combinations of economic resources and health conditions of different senior subgroups may lead these seniors to choose different living arrangements and/or move to different places. These decisions will clearly have land use impacts.

Economic Resources: Housing Choice Factor #1

Housing choices for seniors depend on available economic resources and the flexibility of their use. To understand why seniors make the housing choices they do--where to live or move and the kind of home they live in--an understanding of the economic resources available to seniors is required. Net worth (NW), rather than income, is the most useful measure of the resources available for housing and other living expenditures. To assess NW, this report draws on Survey of Program Participation (SIPP) data, which is most frequently used for this purpose (see Appendix 2).

The Net Worth of Senior and Senior Subgroup Households

Households are the purchasing units of senior housing and the most useful unit of analysis for evaluating senior economic resources available for housing. Charles Longino (1991) compared 1988 and 1984 SIPP data to discern national trends in NW. The average NW of senior households was $102,175 in 1984, ranging from the lowest quintile average of $3,437 to the highest quintile average of $297,442. In 1988, of all householders, median NW was highest among householders age 65 to 69 ($83,500). The NW of the 70-to-74-year-old group was $82,100 and those age 75 plus had an average NW of $61,500. Also, each senior subgroup had substantially greater median wealth than younger age groups even of those with the highest income levels (Longino 1991, 50). Moreover, the median NW of younger Americans (age subgroups below 55) declined substantially at the same time that the NW of seniors increased by 4 to 10 for all subgroups except those of age 75 plus, whose median NW fell by 2 percent. In short, the sources of senior wealth are increasingly diverse and the NW of subgroups ranged widely in the 1980s (see Longino in American Demographics 1991). NW of seniors increased during the 1980s and seniors were relatively better off than younger generations.

Young seniors possessed more resources than older ones. These findings suggest that today's seniors are relatively well-off when compared to other groups, but as seniors age, their resources diminish. Although we might expect households to gain wealth as they mature into their prime earning years, the overwhelming NW advantage of senior groups suggests generational declines in wealth. This may mean that future seniors, particularly those of late baby boomer age and younger, may accumulate far fewer resources available for housing. This

conclusion, however, must be treated with caution. For example, older persons control large portions of individual stock holdings and enhanced their NW during the 1980s stock market boom (Longino 1991, 50). Similarly, since most seniors own homes, they benefitted from the rapid rise in home values during the 1980s. The real estate and stock value declines of the late 1980s and 1990s, however, may have eroded the gains in senior NW. To reach any kind of reliable assessment about the economic resources available for housing decisions by different types of senior households in this state, a detailed analysis of the NW of New Jersey seniors is required, especially in relation to broad economic and housing trends.

Income, employment, and marriage patterns varied across senior subgroups during the 1980s. The trends are not surprising. More affluent senior households (top 20% in NW) tended to be headed by householders who were younger, educated, and married. Young seniors had higher NW with larger shares coming from income earned from part- and full-time employment (Longino 1991, 50). Of the more affluent seniors in 1984, 27 percent were working compared to 17 percent of all seniors (Longino 1991, 50). Affluent seniors had, on average, 3 years of college. In addition, 72 percent of the most affluent seniors lived in married-couple households while only 53 percent of all seniors did. At the other end of the spectrum, of poorer senior households (bottom 20% in NW), 53 percent had near or below poverty levels of household income in 1984 (Longino 1991, 51). Senior women were more likely to be poor than men. Of the poorest seniors, 45 percent were widowed. The poorest senior households tended to be headed by females, the widowed, and the poorly educated. Also, poor seniors in 1984 had on average, a 9th grade education. In other words, groups that were worse off in adult life--the less educated, the poorly paid, and single householders, continued to be so in their senior years (Longino 1991, 51). As a result, these groups are afforded fewer housing options as their needs and preferences change with aging.

Sources of Senior Wealth

The mix of financial resources available to seniors is crucial to housing decisions. Income from employment, investments and savings are usually allocated for living expenses while housing equity is most often an investment to be applied to future moves, bequests, and, if needed, major medical expenses.

Home equity accounted for the bulk of senior NW for all wealth quintiles in 1984.[2] The proportional share of sources of senior wealth varied according to the quintile of NW under examination. The most affluent 20 percent of seniors in 1984 (with a $297,442 average NW), invested in home equity (average $88,603), stocks and mutual funds ($49,881), equity in rental properties ($22,119), financial institution-based interest earning assets ($19,641), and business equity ($13,647) (Longino 1991, 51). Of these wealthier senior households, over 94 percent had assets in home equity, financial institution-based interest earning assets, and autos; 68 percent had money owed to them by friends and family and while 51 percent held stock and mutual fund assets.

[2] Wealth quintiles are derived by arranging the wealth values of all senior households in descending order. The range of values is then split into five equally sized groups. Values falling within the first 20% of all values between 21 and 40%, 41 and 60%, 61 and 80%, and between 81 and 100% are quintiles. The mid-point value is the median with where half of all cases are below it and half above.

The poorest quintile of senior households, with an average NW of $3,437, held most of their assets in home equity (average $1,522), financial institution-based interest earning assets ($1,374), and automobiles ($941) (Longino 1991, 51). Less than half (45.9%) of poorer seniors retained financial institution-based interest earning assets (usually in the form of bank and thrift deposits), over 44 percent owned autos, about 40 percent had money owed to them, and just over 19 percent held home equity. Interestingly, even poor seniors had substantial economic resources tied up in homes. One quarter of poor seniors held over $50,000 in home equity in the mid-1980s (Longino 1991, 51; U.S. Department of Housing and Urban Development 1986 in Gibler and Rabianski 1993, 567).

Finally, the middle quintile of senior householders possessed an average NW of $66,446. Almost 89 percent owned financial institution-based interest earning assets averaging $1,321, while home equity assets averaged $39,659. Over 81 percent owned autos and over 61 percent had money owed to them.

Several useful patterns can be gleaned even from this cursory review of NW data. Home equity is an important investment for all but the very poorest seniors. Moreover, a sizable number of poorer seniors also had home equity. Most seniors, rich and poor, have money owed to them, usually in the form of interest-free loans to their families, an asset they believe they can use in the future (Longino 1991, 52). Although seniors of all NW levels invest and save, those with greater NW have more diversified and sophisticated holdings. Whether they are more or less subject to investment volatility is unclear. They are, however, less dependent upon investment income for basic expenses. Finally, auto ownership constitutes a fair share of senior assets. This may partly explain why public transit is not a particularly important community attribute of interest to seniors (see below).

Some of these assets are less accessible for use in housing-related decisions than others. Home equity and many of the more complex investments are not fluid, and their relative utility to finance relocations moving depends much on a variety of sales, real estate, and income tax laws and the relative price of replacement housing. Some sources of income, such as interest, dividends, wages and salaries, are more accessible and relatively reliable. However, as was true in the late 1980s, income garnered from even the simplest investments, such as certificates of deposit, can deteriorate due to interest rates variations. Finally, senior employment income is substantial, particularly for young seniors. Any labor force shortages accompanying the baby bust and beyond may further increase the employment possibilities for future seniors.

Housing Equity

More than other assets, housing equity affects housing options directly. Housing choices are made in reference to past and current living arrangements. Also, housing decisions made in earlier stages of life, in large part, determine the resources available for housing options in later life. Those who can afford it choose to own a home. Furthermore, the deductibility of home mortgage interest, easy access to mortgage insurance and guarantees, rising real estate values over several decades, and cultural norms have all contributed to high levels of home ownership among seniors. Indeed, home ownership among seniors stood at 75.4 percent in 1984 (Longino

1991, 51). As a result, home equity now constitutes the bulk of senior wealth. In part, home equity underscores the importance of wealth, rather than income, to housing decisions. Housing equity in many cases is protected more than other income and assets. For example, home equity need not be used to pay nursing home bills in some states. Conversely, some constraints that seniors experience in solving housing-related problems stem from the rigidities of home ownership. For example, those who opt to convert home equity to income face a complex evaluation process in deciding if this is the best way to allocate their resources.

Income Sources

Income, rather than wealth, serves as a measure of the economic resources available for seniors to purchase housing, for senior homeowners to buy maintenance, improvements and modifications, and for all seniors to purchase services and living necessities.[3] More detailed research on the income resources of New Jersey's seniors should reveal trends in the sources and levels among subgroups, which is necessary to evaluate income susceptibility to economic trends such as changing interest rates, taxes, and changes in pension, Social Security, Medicare and Medicaid benefits. Further, such research could yield analysis of income patterns by household type and furnish an index of effective housing demand for particular housing types in the state.

Table 1:
Income Sources and Median Values of Senior Householders, by Age Subgroup, 1991 .

Age Group: **Source**	**65-74**		**75-84**		**85+**	
Social Security	91.3%	$8,160	96.4%	$7,700	94.2%	$6,800
Interest	72.7	1,928	71.1	1,796	70.5	1,460
Pensions	45.1	6,996	36.7	4,800	26.7	4,069
Dividends	21.0	1,302	18.6	1,500	14.2	1,750
Wage and salary	36.7	12,500	15.9	9,000	8.4	8,000
Public assistance	1.3	2,820	1.1	1,800	1.6	1,480
Disability benefits	2.1	5,808	1.0	5,031	1.0	5,904

Source: Waldrop, Judith. 1992. Old Money. American Demographics. April. p.25. Based on the 1991 Current Population Survey, Bureau of Census.

[3] This is true in terms of flexible income in general. A detailed analysis of the amounts and sources of senior wealth of subgroups could evaluate different assets as potential resources for purchasing housing-related goods and services. For example, improvements in equity conversion programs might make the vast stock of senior home equity more available and acceptable as an income source for more seniors.

Nationally, the median income of households headed by 65-to-74-year-olds was $20,314 in 1991 (American Demographics 1992, 31). Of households with heads ages 75 to 84, the median income dropped to $13,740, and for those headed by seniors 85 years and over median income fell to $10,800. Most senior householders in different age subgroups received income from the same two sources in 1991 (see Table 1). More than 90 percent of the three age subgroups collected Social Security (SS) payments and more than two thirds earned interest income. The percentage of senior householders receiving wages, salaries and pensions, however, differed for each age group, with fewer older seniors receiving each of these.

Social Security

Although high percentages of senior households received SS checks across all these senior subgroups (65-74, 75-85, and 85 plus) the median amount was less for the older age groups in 1991. Of those households that did collect SS, half in the 65-74-year-old group received under $8,160, while half in the 85-plus group collected under $6,800 in 1991. This is due to the fact that there are a higher proportion of single-person households headed by women in the oldest group. This means that fewer of the older households were collecting two SS checks and the amounts received by those who did collect SS were based on shorter work lives and lower incomes at retirement.

Interest and Dividends

Over 70 percent of all senior households earned interest income, second only to SS. Most seniors, however, earn relatively little from this source. Over half of all young senior households earned under $2,000 in interest in 1991, more than half of older households earned less than $1,500. In contrast, dividends were held by fewer older senior householders, but the median value of this income was higher for older seniors than for younger ones. About 21 percent of young seniors and about 14 percent of older seniors earned dividends in 1991. The median income for these two groups was about $1300 and $1750, respectively.

Pensions

The percentage of householders earning income from pensions decline with age. While 45 percent of younger senior householders received pension income, only over a quarter of the old-old had pensions in 1991. Half of the former received less than about $7,000 and half of the latter collected less than $4,000 per year. Recent retirees, even those opting for early retirement, had better pension benefits than older retirees in 1991.

Wages and Salaries

Well over one third of young senior households received wages and salaries from part- or full-time employment.[4] This rate dropped considerably for the older subgroups. Just over 15

[4] This data should not be construed to represent the percentage of seniors earning wages and salaries. Senior households are identified by the age of the householder. Some income may come from younger persons in the senior household. In general, this is inconsequential since housing

percent of households headed by 75-to-84-year-olds, and over 8 percent of those headed by those age 85 and over collected wage and salary income in 1991. For all three age groups, median wage and salary incomes were highest when compared to other forms of income. Half of the young senior households received over $12,500, half of households in the 75-to-84-year-old group received over $9,000, and half of households in the old-old group received $8,000 from wages and salaries. Considering that median senior total household income was about $20,000 in 1991, wages and salaries clearly represent a very substantial income source for many senior households.

Public Assistance and Disability Benefits

Even though there was a large number of poor seniors in 1991, especially in the old-old group, in 1991, less than 2 percent of any subgroup received public assistance. Very-low-income seniors collected transfer payments from the small Supplemental Security Income Program (S.S.I.) (see Appendix 2) (Waldrop 1992, 30). Disability benefits, also distributed through the S.S.I. program, accrued to only 1 to 2 percent of all seniors despite the high rate of senior disability. This is because jobs offering disability benefits were rare until fairly recently (Waldrop 1991, 30). In general, as disability benefits expand, we can expect greater numbers of seniors to collect benefits in the future. The decline in disability rates associated with many occupations, however, suggest lower rates of disability and thus, lower disability income for tomorrow's seniors. On the other hand, spiraling disability rates in some rapid growth fields, such as health care workers, suggest more disability income for future seniors (Bureau of Labor Statistics 1994). A detailed analysis of future senior disability incomes should take into account job-related disability rates and trends in disability benefits and law.

In summary, seniors had a range of sources of wealth and income in 1991. Home equity served as a key form of wealth, as did simple investments and family loans. Employment and social security, in turn, contributed significantly to income and wealth for many seniors. Pensions, disability benefits, and public assistance, on the other hand, covered far fewer seniors than one might have expected. This contributed, at least in part, to the differential patterns in NW and income among the various senior age groups. Also, although senior average net worth was relatively high compared to other age groups, senior NW and income was much less in the older groups and among single households.

The Future of Senior Income and Wealth

Social Security

There is great concern and inter-generational tension over the ability of SS to generate sufficient resources to meet the demands of the baby boom generation when it reaches retirement age. Some forecast that the SS trust system, supported by the contributions of a decreasing number

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resources are pooled and housing decisions made by households rather than individuals. Nonetheless, trends towards greater proportions of single person households will influence earned income and other sources of household wealth in the future.

of younger workers who are experiencing absolute declines in their wage and salary income, will enter bankruptcy by the year 2040 (National Public Radio 1994). Inter-generational competition may lead to political battles to reduce SS and Medicare benefits, eliminate Medicare coverage for upper-income and middle-income seniors, and curtail senior energy cost assistance programs (Smith 1994; National Public Radio 1994; Estes 1992, 295). Others argue that such drastic measures are unnecessary. Although the portion of SS trust funds allocated for benefit payments will increase from the present level of 11.5 percent to about 14 to 16 percent beginning in 2015, budgetary techniques that use SS funds to underwrite federal budget deficits are thought to be the culprit and are thus correctable (Moynahan 1994). Furthermore, demographers argue that four forces are at work to stabilize the flow of resources into the SS system (see Waldrop 1992, 32). First, recent generations of young workers have negotiated better retirement plans. Also, concerns over secure retirement incomes have encouraged workers with substantial resources to invest in alternative retirement plans. These efforts, however, will only lessen pressure on the SS system, if retirement income levels in benefits packages are commensurately lowered . Second, in recent decades, disability programs have been enlarged to cover more jobs and workers. In this way, it is argued, more disabled seniors will be eligible for disability benefits in future. Third, as more women have entered the work force, contributions to the SS system have increased. And, at least in the near term, older women who draw SS will not draw nearly the amount that working women will contribute to the system. Finally, the life expectancy of men rising. As a result, there will be a decline in the percentage of married women who experience income cuts when their husband dies, which has often been by well over half. For those who do become widowed, the average number of years of widowhood will be fewer. Similarly, more women have begun to earn their own pensions and, it is argued, as women slowly gain entry into some better paying jobs, their pensions will serve as more substantial sources of retirement income (Waldrop 1992, 32). Barring the success of some recent efforts to reduce pension benefits, improvements are expected in the pension incomes of future seniors (NJDCA 1990, 141). Indeed, pensions could become the largest source of future senior income (Waldrop 1992, 31).

All of these trends, however, would not decrease SS payment outflows since these payments are based on income levels at retirement, not on the total income of individual retirees. Still, if these optimistic predictions prove reliable, more seniors will receive income from sources other than SS. As a result, we might assume that the average incomes of seniors will rise. Alternatively, other income sources may just replace SS for some seniors, resulting in little or no net income gain (Waldrop 1992, 32). Politically risky and untested policy interventions might be needed to reorganize the distribution of SS benefits. In any event, the balance between and values of entitlements and other sources of future senior incomes will heavily influence the ability of seniors to make housing decisions. This topic requires careful analysis over time to predict the housing and land use impacts of shifts in senior income sources and amounts.

Fluctuating Interest Rates

Much attention has been focused upon the effect of lower interest rates in the early 1990s on the income of seniors. In particular, interest income from certificates of deposit, a stable and comprehensible income source for many seniors, has declined precipitously. Fluctuating interest rates will effect the incomes of future seniors. As more workers ply more sophisticated

long-term investment tools in their retirement planning, such as tax-deferred Individual Retirement Account and Keogh plans and annuities, mutual funds, income from these sources may become more difficult to predict.

Education and Employment

Increasingly, higher levels of post-secondary education attainment and longer work lives will be two factors that could improve the income of seniors between 1990 and 2030. The income gains of college-educated women between 1979 and 1989 began to close the income gap between women and men, suggesting long-term gains in womens' income (Department of Labor 1994, 1).[5] Also, rising rates of labor force participation and longer work life spans of all workers may increase the income and wealth of households. And, higher rates of labor participation among seniors should help to increase income levels. Longer work lives may also lead to deferred decisions to change housing arrangements and locations among working seniors. In short, trends in education, and gender- and age-related labor participation and earnings could engender higher incomes in future for seniors, as well as postponed housing decisions.

Household Size and Income Levels

As households include greater proportions of single-person households, lower household wealth and income may result. Similarly, the stagnant wage and salary levels of younger cohorts in recent years may mean that the average income, in the form of wages, salaries, pensions, SS, and disability payments may fall as these workers reach their senior years. Simply put, these trends may counteract any income gains.

Understanding the relative NW and income of New Jersey's current and future seniors, when coupled with knowledge of housing finance and housing cost trends, senior housing preferences and needs, and age-related employment, and commutation patterns, provide a good basis for anticipating many of the land use impacts of the state's aging population. Clearly this issue depends on many variables, is complex and deserves a more thorough analysis of all these variables.

Economic Resources Relate To Housing And Service Costs

Housing Costs

Nationally, seniors have fewer problems finding affordable housing than do the rest of the population (see Schwartz 1988, 189). Home ownership has increased among seniors, and at least 80 percent of senior household heads carry no home debt (Kennickell and Shack-Marquez in Gibler and Rabianski 1993, 567). Also, home ownership has afforded seniors virtually rent-

[5] This analysis, however, was based upon the Current Population Survey and calculates income not only on the basis of wages and salaries, but also interest, dividends, rents, pensions, unemployment compensation and other sources.

free housing and fairly predictable housing costs. In addition, most seniors enjoy housing that is of good quality and supplies sufficient space for their needs (Schwartz 1988, 189).

Nonetheless, more vulnerable senior groups face high housing costs. Of all persons who own a home, live alone, and live in poverty, over half are seniors. In addition, many seniors, although not impoverished, endure financial stress related to housing costs. Some scholars estimate that seniors aged 75 plus expended half their income on housing in the 1980s (Monk and Kaye 1991, 6). The median rent of a senior women living alone was well over half of her income (Schwartz 1988, 178). Furthermore, many more seniors spent over one-third of their income on housing.

Housing costs vary substantially by region. New Jersey cost data would be most useful in predicting New Jersey's future senior housing patterns. Detailed studies that review the housing costs of the state's seniors, as a distinct group, however, have not been conducted recently. It is known that housing costs in the state are high and have risen rapidly. A housing study for the total population found that New Jersey's housing prices rose rapidly in the 1980s followed by a decline in the early 1990s. (see Dolan 1990). For example, by 1988, less than one third of homes sold in the state that were affordable to New Jersey's median income households. Additionally, only 16 percent these homes were affordable to moderate-income households. The relevance of new home affordability is only indirectly related to senior housing decisions since the majority of seniors already own their homes. But, newer, smaller housing alternatives, such as condominiums or cooperatives, are attractive to seniors because they offer less burdensome maintenance. The high costs of these units, however, can prevent seniors from engaging in equity swaps. This is particularly true for seniors who own homes in areas with low home values who would like to move to other parts of the community because they may have difficulty finding lower cost housing. In 1990, 27 percent of the state's senior home owners paid at least 30 percent of their income on housing costs and utilities (N.J. Division on Aging 1993). Whether these seniors are unable to find lower cost units, or had other reasons for continuing to pay high proportions of their income on housing is unclear.

New Jersey's renters experienced high and increasing housing costs as well. Rents rose much faster than the consumer price index in the 1980s. As a result, 57 percent of the state's senior renters paid at least 30 percent of their income on housing costs and utilities in 1990 (N.J. Division on Aging 1993). To ascertain fully the relationships between housing costs and seniors ability to afford, and locate appropriate housing and necessary services a closer scrutiny of available data is necessary.

Housing Quality and Maintenance

Housing quality is also a problem for seniors, albeit to a lesser extent than is affordability. Estimates of the pervasiveness of poor quality housing among seniors vary considerably. Abraham Monk and Lenard Kaye (1991) found that 30 percent of the nation's seniors lived in substandard housing (without central heating or complete plumbing and kitchen facilities) in 1990 (6). Stephen Moore (1992) based on data from the 1982 National Long Term Care Survey (see Appendix 1), estimated that 11 percent of senior men and over 18 percent of senior women lived in deficient housing (119). Also, of all impoverished seniors, 29 percent of men and 41 percent of women inhabited physically-deficient buildings (Moore 1992, 119). Additional

research is required to estimate the percentage of New Jersey seniors who live in physically-deficient housing.

Senior residential units are substandard, in part, because of their age. Sixty percent of the nation's senior homeowners live in homes built before 1939 (Monk and Kaye 1991, 6). Forty percent live in housing more than 40 years old. These older units tend to have poor insulation, higher heating costs, and higher maintenance costs than newer ones. Moreover, the cost of maintaining older housing may be the reason why some seniors live in poverty. Abraham Monk and Lenard Kaye (1991) found that the close relationship between housing deficiencies and permanent poverty among seniors is associated with: (1) high costs of maintenance and local taxes; (2) shrinking rental housing stock; and, (3) waning government housing assistance programs (7). All of these factors have been decade long trends which are not likely to reverse or change in the near term.

Home Modifications

In general, only the more affluent, healthy or mildly disabled seniors can afford to modify their homes for more independent functioning (Mitchler and Burr 1991, 378). More moderately disabled seniors must figure out how much living space modification and how many personal and home services they can purchase, for how long, and to what degree family members can provide some of these services. Home modifications and personal services can defer or prevent institutionalization, but are very expensive (Mitchler and Burr 1991, 378). Little detailed research is available on the exact costs of such services and to what degree they affect New Jersey's seniors housing decisions.

Disability: Housing Choice Factor #2

Community Responsibilities and the Disabled

Disabilities are the second most important factor influencing senior housing decisions (Mitchler and Burr 1991). Because such a large number (about 20%) of seniors have at least one disability, we can assume that many seniors are faced with disability-related housing decisions. The nature of these decisions, however, may be undergoing rapid change. As a direct result of the political pressure applied by disabled persons, public attitudes about and cultural expectations of disabled persons have been radically altered in the past 2 decades. The Americans with Disabilities Act of 1990 is the most obvious manifestation of this transformation. The Act requires that buildings, infrastructure, employment, and housing be more accessible to disabled persons (see Appendix 3). As a result, communities, property owners, and employers must make greater efforts to eliminate barriers to disabled persons. In addition to legislative efforts, there has been an explosion in the development of consumer equipment and technology that enable disabled persons to function more independently. These trends are anticipated to continue with a range of possible consequences. For example, there may be lower rates of institutionalization and home-confinement among seniors in the future. Also, for those seniors who must move because of disabilities, different choices may be made. Also, as has been the case in the past, physical changes to community facilities and infrastructure may have unexpected benefits for the whole community.

Disabilities and Community Planning

To anticipate future needs and patterns, community planners, housing and residential facility developers, policy makers, and service providers must develop better measurement and needs assessment methods (Harlow and Turner 1993). Intrastate funding decisions pertaining to aging agency programs and health facilities in local communities more and more depend upon precise definitions, counts, and estimates of disabled populations (Harlow and Turner 1993, 191). Furthermore, current trends suggest that the inability of residents to use community facilities will serve as an important outcome measure in evaluations and their associated distribution of public resources, which range from health facility funding to federal infrastructure support (Harlow and Turner 1993, 191). Currently, 44 states engage in very limited needs assessments of their elderly populations (Harlow and Turner 1993).

Senior Disability

Most seniors live independently and without disabilities. More than three quarters of all seniors are not disabled and over half of the 85+ group are disability free. Moreover, senior independence in the home is on the rise (Longino 1991, 34). Nonetheless, as noted, a substantial proportion of seniors have one or more disabilities (see Golant 1992, 33-38).

Research on senior disability is typically divided between the institutionalized and non-institutionalized population. Only 5 percent of America's seniors are institutionalized (Golant 1992, 33). Based on National Survey of Medical Expenditure research, 13 percent of non-institutionalized seniors had at least 1 Activities of Daily Living (ADL) impairment prior to 1990, most frequently bathing or walking (see Appendix 1). Eighteen percent of non-institutionalized seniors had at least 1 Instrumental Activities of Daily Living (IADL) impairment, usually shopping and getting around the community. Also, almost 20 percent of non-institutionalized seniors had at least 1 ADL or 1 IADL impairment. Not surprisingly, as seniors age, these rates increase. Over 50 percent of non-institutionalized seniors age 85 plus had at least 1 ADL or 1 IADL impairment. Based on 1982 National Long-Term Care Survey data, Stephen Moore (1992) found that almost 40 percent of men and 48 percent of women in the old-old group had 1 IADL impairment (119). And Stephen Golant (1992) found that close to 10 percent of this older group had 2 or 3 ADL impairments (33). It is this frail senior group (with 2 or more ADL limitations) in the 75 plus age group that is expected to grow rapidly in the 1990s and experience high levels of unmet housing needs in personal and home services, home modifications, or alternative residential options (Harlow and Turner 1993, 191). There may be an even greater need for alternative residential facilities and services by the 2020s, barring improvements in general health or disabilities in the population and / or innovations in treatments for illnesses and technology. More research is required to assess new facility development to serve this population in New Jersey.

Services and Equipment for Disabled Seniors in the Community

Very few seniors with IADL impairments (1.3 percent) and ADL impairments (1.8 percent) were able to perform the affected tasks without help (Golant 1992). "Help" is measured in

terms of human assistance and/or the use of equipment (which may include some forms of housing modification). For seniors, help usually comes in the form of assistance from other persons. Equipment alone improved the independent ADL functioning of only 2.9 percent of disabled seniors in the community (Golant 1992, 34). Moreover, even with personal help, only 9.4 percent of seniors with IADL impairments were able to perform the relevant task. Nonetheless, Stephen Moore (1992) claimed that about one third of the disabled seniors would benefit from housing modifications (120). Many seniors, however, do not make home modifications because of the expense or because they lack knowledge about what is possible (see below). Furthermore, although equipment and modifications have enabled a large portion of the entire disabled population to function more independently, improvements have been less impressive for seniors. Nonetheless, environmental modifications through structural changes, new technology, and equipment will be important trends to watch to determine future housing and service needs of the disabled senior population.

Senior Subgroups Vulnerable to Disability

Stephen Golant (1992) described the socio-economic and age-related physical changes that predispose particular seniors to disabilities. Blacks, the poor, persons living alone, and those unmarried without children had higher rates of disability (1992, 34). Non-institutionalized women in all senior age subgroups were more likely than men to be frail (Golant 1992, 35). Also, seniors with declining vision, impaired hearing, and deteriorating cognitive function were more prone to have functional problems in their housing and communities.

Income and education were found to be significantly associated with different disability rates among seniors (Manton, et al. 1993). For example, seniors with 16 or more years of education had 42 to 67 percent lower rates of disability than those with 11 or fewer years (1993, S163). The non-poor had 59 to 60 percent lower disability rates than the poor. Kenneth Manton, et al. (1993) also found improvements in disability rates due to higher education levels associated with the GI bill and higher incomes in the 1960s. Manton, et al. (1993) speculated that continued improvement in educational achievement will further reduce the disability rate of tomorrow's seniors. However, they caution that despite the declines in disability rates, there will also be absolute increases in long term care needs as the size of the senior population grows (Manton, et al. 1993, S164). Also, Manton, et al. (1993) discovered that for some high risk groups (younger, educated, but low-income central city seniors), disability rates risen.

Changing Rates of Disability

Although disability rates have not changed dramatically over time, some research indicates that national rates or the incidence of chronic disability has declined, albeit at different rates for chronically disabled seniors in community dwellings and institutionalized elderly populations from 1982 to 1984, to 1989 (Manton, et al. 1993, S153). Also, the number of long-term disability days increased, but bed disability (the most severe) diminished between 1970 and 1980 (Manton 1993, S162). These authors found that disability rates have dropped substantially in populations undergoing treatments for illness and in the general population with particular disabling conditions. Declining morbidity for some conditions, prevention measures, and more effective treatments have all contributed, to varying degrees, to the decline in disability rates.

Specifically, treatments for osteoporosis, geriatric evaluation units, and lifestyle changes have cut disability rates substantially. Manton, et al. (1993) anticipate further reductions in the rate of disability among the elderly as a result of advances in the understanding of disease histories and the risk factors associated with disabling conditions, such as pulmonary dysfunction and the dementias (S162-163). Also, trends in the early intervention into disabling diseases show promise. Together, these findings portend potentially lower rates of disability among seniors in the long-term. However, the additional possibility of new yet unknown diseases and conditions appearing in the next century cannot be ruled out.

Residential Facilities for Disabled Seniors

The services and facilities required by disabled senior populations will change over time. Manton, et al. (1993) expect a shift to community-based care and greater use of disability-related equipment in the future. The political and economic support for these changes, however, is uncertain. In addition, as discussed above, although the quality of life may be improved for disabled seniors, equipment helps only a small percentage of the disabled to function independently. This means a greater need for professional and para-professional help will result. At the same time, there are already severe shortages in resources devoted to providing these services, such as public funding for trained workers willing to enter these fields (Burnbridge 1993). The ability of many disabled seniors to remain in their homes or to move to the least restrictive alternatives will depend on increased funding and an adequate supply of skilled workers.

Predictors of Nursing Home Admissions

Nursing Home Residents

Five percent of the senior population live in a nursing home (NH) at any one time (see Appendix 2). Only 1 percent of young seniors, 6 percent of those age 75-84, and 22 percent of the old-old lived in nursing homes in 1990 (Mitchler and Burr 1991, 375). Still, researchers estimate that 25 to 45 percent of seniors will be institutionalized at least once, usually following a short term acute care hospitalization (Golant 1992, 39). Most seniors who enter these facilities stay less than one year (Golant 1992, 39). Thus, a portion of the nursing home population is transient, moving on to other housing arrangements after discharge. In addition to being a more transitory population, nursing home residents have become older, sicker, and more disabled; a trend expected to continue (Golant 1992, 40). As a consequence, we can expect these facilities to modify the services they offer over time. For example, more staff may be required, increasing the proportion of nursing home beds devoted to skilled nursing care. It is unclear, however, whether these particular shifts will effect changes in nursing home size, structure, number, or location. Rapid restructuring in health care policy, financing, and delivery systems are the more likely origins of these sorts of changes in nursing home facilities.

Admission Risk Factors

Multiple risk assessment studies have attempted to identify predisposing factors for nursing home admissions (see Golant 1992). Overall, risk predictors explain less than 20 percent of the

variability in admission rates. Mental disability, older age, the need for assistance in ADL and IADLs, recent hospitalization, and being white were high risk factors. Financial status, mortgages, housing quality, nonmetropolitan locations, widowhood, living alone, general physical dysfunction, and Medicaid eligibility were not important predictors. Some data indicates that seniors with children are less likely to be institutionalized (Mitchler and Burr 1991, 378). But, in a longitudinal study controlling for factors such as health, income, and demographic characteristics, Jan Mitchler and Jeffery Burr (1991) found that children had no bearing on the likelihood of institutionalization. Rather, health status was the most significant factor in explaining senior institutionalization, while economic and other resources were more important in explaining housing arrangements. Mitchler and Burr (1991) concluded that seniors are institutionalized foremost because of illness rather than other factors.

Other Influential Factors

Although economic resources, health status, and disability are the most important factors in determining the particular living arrangements or institutionalization of seniors, other factors should not be ignored when constructing projection models of senior subgroups and new housing locations. Age, in particular, and sex and marital status all influence the timing of these decisions (Mitchler and Burr 1991, 387). Also, many changes in living arrangements stem from housing problems. A variety of economic, demographic, health, and social factors often conflate in producing housing problems for seniors. Those who suffer higher risks of severe housing problems have multiple predisposing characteristics (that are discussed below in greater detail). For example, seniors living alone are more at risk. Also, among those who live alone, some groups have an even higher incidence of housing problems. These seniors tend to be older (80 plus) widowed women, who have lived alone for a decade or more, in fair to poor health, are poor, generally with a small or no pension income, are dependent on SS, have large medical debts, and have no children nearby to assist them (Golant 1992). In short, those in greater need of assistance, particularly in the areas of health care and finances, are more likely to have housing troubles.

One thing is certain, disabilities heavily influence senior housing decisions. Political pressure to broaden community accessibility and assure improved community functioning by disabled persons has moved planners and policy makers to respond. In addition, although few seniors are institutionalized because of their disabilities, many seniors have 1 or more disabilities that require home modifications of that involve personal care assistance. Some groups are especially vulnerable and needy and require special services. But, labor force and program funding trends have reduced severely inadequate services for the disabled senior population, which will probably not change in the near future. Also, although the disability rates associated with some conditions have declined, perhaps leading to long-term reductions in personal care needs in the future, absolute population increases in the senior group will probably result in greater demand for long-term facilities.

SECTION II

THE RESIDENTIAL PREFERENCES OF SENIORS

The Ideal: What Kind of Housing Is Optimal?

Some scholars argue that "neither housing or community-based care alone adequately meets the needs of low-income seniors" (Moore 1992, 123; see also Pastalan 1990). The functional separation of housing, health and services policy seldom enjoy interagency collaboration (Moore 1992, 120-121). has stymied better solutions to senior problems. More recently, public policy has shifted towards re-integrating health and housing for seniors. For example, although heralded as creative, joint demonstration models such as group homes, shared homes, and adult foster care have also been judged to be too impractical on the massive scale needed to accommodate the future growth in the senior population (Moore 1992, 122). Moore (1992) recommends, instead the development of policies that would be simpler to put in place, such as building "enriched senior high-rise apartment structures" located near the necessary health and social resources, and equipped with service components, properly designed units using advanced technology, appropriately trained staffs, and ancillary vendor services, such as hair salons and laundries (122). Providing senior units with more appropriate levels of service would have the added benefit of opening up regular senior housing units to independent seniors in the community, and, in turn, free up homes for younger households and others in need of affordable housing.

Lenard Kaye and Abraham Monk (1991) argue for the development of "supportive environments that take into account both individual personal capabilities and the characteristics of the environment" (127). Seemingly simple, this idea is relatively new and has pervaded the literature on aging of the late 1980s and early 1990s. The concept is undergirded by the medical model and disability studies. Briefly, together these models prescribe individually-tailored services by trained personnel and neighborhood facilities and spaces designed or retrofitted to better integrate seniors into the community (Pfeiffer, 1993).

As Moore (1992) notes, many states are experimenting with such models, but these have tended to be inadequately funded demonstration projects. Despite the appeal of the enriched senior high-rises and similar projects, Moore warns that, as has been the case with other programs for seniors, the efficiency and long-term cost savings of enriched senior high-rise structures will be difficult to demonstrate and therefore have not garnered broad political support (1991, 123). Also, adding new funding for new senior housing, although needed, runs counter to most public policies that have eliminated and reduced senior housing development financing incentives and cut program funds for senior housing and services. In New Jersey, trends suggest continued shortfalls in housing and services for those most in need (see (Appendices 5 and 7). As construction of senior housing dwindles, service funding is more and more limited, and the development of demonstration projects is extremely marginal. This is happening at the same time that the eligible senior populations are increasing, with little hope for change in the near future.

Residential Preferences

Housing choices are made within the parameters of available housing forms and available services and facilities rather than what might be the ideal. This section will describe senior preferences for various housing and community types with particular attention to alternative

living arrangements and migration patterns. These preferences are gleaned from research on interests expressed by seniors in and actual choice of various housing types and community arrangements.

Aging in Place: The Greatest Desire

Housing Preferences

Most American seniors want to stay put. Of all persons age 55 and over in 1989, 86 percent wanted to remain in their present home for the rest of their lives, an increase of 11 percent since 1986 (AARP 1990, 8).[6] Also, the American Association of Retired Persons (AARP) found that 40 percent of seniors preferred age-segregated buildings over those with mixed age groups, up from 32 percent in 1986. Further, for the first time, the majority of seniors evinced an awareness that at some point, they will need assistance with the more strenuous household activities and may need different housing altogether. Nonetheless, over half of these seniors have done little to no planning for their future housing needs. But most of these non-planners are over 75, poor, and single. In other words, these seniors may have few options available to them.

Community Preferences

The AARP also found that, if seniors had to move, over three-quarters of those aged 55 and over wanted to live in a mixed-age neighborhood (1991, 9). Also, one third preferred to live in a small town, one fourth in the suburbs, another fourth in the country, while 13 percent preferred a city. Of all respondents, 65 percent have lived in the same geographic area for more than 20 years (AARP 1991, 28). Respondents also identified those services that were absolutely or somewhat necessary to have available within a half-mile. These included a grocery store, pharmacy, doctor's office, and a hospital. Public transportation, children and grandchildren, cultural resources, a senior center, and recreation facilities were less important to have nearby.

Despite the desire to stay in their current home, 30 percent of persons 65 plus move (Monk and Kaye 1991, 7). Of those seniors who do move, however, only 6 percent move in any one year. Also, only 3 percent buy or rent new homes (Baldwin cited in Monk and Kaye 1991, 7). More systematic research is required, however, to determine where seniors move and into what kinds of living arrangements.

Migration models explain senior relocation by dividing the reasons into "push" and "pull" factors. Judith Gonyea, et al. (1990) studied the pull and push factors affecting the housing preferences of suburban seniors in Massachusetts. Pull factors included the amenities associated with improving one's lifestyle (Gonyea 1990, 82). Push factors, however, exerted greater influence on the decision whether to move or not, and were far more significant for more vulnerable seniors (renters, the economically and functionally vulnerable, and the socially isolated) (Gonyea 1990, 82).

[6] This survey used random-digit dialing of senior households included in the Market Facts TeleNation service. The sample over-represents seniors with college degrees and incomes over $20,000 when compared to census estimates.

Preferences of Those Who Foresee Moving

Seniors who foresee the need to move believe they will do so because of an inability to attend to household maintenance and / or will require more services. Granger and Kaye (1991) found that 28 percent of healthy, middle-income respondents were interested in relocating to housing that included special services (see Appendix 4). Of these, three-quarters preferred living outside central cities (Granger and Kaye 1991, 65). Both urban and suburban dwellers were more receptive to the idea of moving to rental units than were rural and small town residents (72). Under two-thirds of seniors who foresee moving wanted two-bedroom units, the other third wanted one-bedroom units. One third preferred a low-rise building, but two-thirds would be happy with any size building (65). Also, building-based security, emergency call buttons, and on-site parking were the preferred amenities. Preferred community facilities were grocery stores, doctor's offices, pharmacies, beauty / barber shops, dry cleaners, and nursing and home care services (65). Housekeeping and meals were the services that seniors wanted in their homes (65). Leisure activities of interest included walking paths, religious services, a library, social / recreation staff, and a pool.

Seniors interested in service assisted housing (SAH) (23% now and 39% in future) showed no significant demographic differences from those who did not, except in their housing tenure. Renters were slightly more interested (Granger and Kaye 1991, 66, 64). The most significant characteristic of those that expressed interest in SAH was attitudinal. That is, seniors who want to move to these units desired to do so while they were still healthy and independent (66). Persons interested in SAH view it "as a housing option and were not concerned with a loss of independence but instead anticipated freedom from household 'drudgery'" (68, 71). Those not interested in SAH valued it instead for its "supportive services" (Granger and Kaye 1991, 68). The other significant characteristics of persons interested in SAH were with the problems they experienced with home maintenance and poor health. While income was not a statistically significant variable for interest in SAH, most seniors were interested in paying less for their housing.

Unfortunately, programs promoting or offering assistance for these housing options, such as SAH, are used by few seniors (Varady 1990). David Varady (1990) contends that this may be because programs do not reflect an accurate understanding of senior housing decisions. Moreover, planners and policy makers have little understanding as to why their housing and service programs are underutilized (Varady 1990, 88). He argues that while some research has been carried out on seniors who, for example, have built accessory apartments in their homes, and on the tendencies of program administrators to select less needy seniors for their programs (see Hare and Guttman 1984; Lawton 1980; Kahana et al. 1976; Schreter and Turner 1986; Turner and Mangum 1982; and Varady 1985), the extant research has not assessed the actual demand for different housing options among seniors. Varady (1990) claims, based on preliminary findings, that senior subgroups at risk for premature institutionalization have the highest level of interest in accessory apartment conversion and home sharing programs. This cast into question the conventional wisdom that better off groups generate greater demand for and make more extensive use of these programs (1990, 97). He concludes that policies should be modified to provide low interest loans, counseling, referral and technical support services in

conjunction with senior housing programs to expand the number of seniors that could benefit from the programs.

Aging in Place

Several studies report that the overwhelming suburban demographic trend as "aging in place," not the in-migration of seniors or the out-migration of younger groups (Gonyea, et al. 1990, Gaff and Wiseman 1978). That is, these studies have shown that seniors tend to remain living in the same place (AARP 1988, Longino, et al. 1987, Huemann 1987). Literature on helping seniors age in place emphasizes studying locally Naturally Occurring Retirement Communities (NORCs) to determine what makes those places work for seniors and to use NORCs as models when designing housing alternatives for seniors with housing problems (Hunt 1991, 127). Preliminary evidence suggests that some areas of New Jersey have many NORCs.

Pierre Filion, et al. (1992) found that seniors who preferred to remain in their homes and anticipated difficulty in doing so, planned on employing paid help for household and personal care tasks. This finding was consistent with other research on the preferences of seniors in a variety of alternative housing options (see Appendix 5). Most older seniors (75 plus) are content with their homes as they are, tend to live day to day, give little time to housing choices when planning their future, do not seek out support services, and either do not make design changes or make very minor ones to their homes (Filion, et al. 1992, 3). If these seniors used services, it tended to be home care. Filion (1992) attributed these tendencies to mental attachments to familiar household characteristics and social relationships that minimize the inclination to make changes (24). These studies concluded that while seniors want to remain in their homes, they also prefer to cope on their own. More importantly, the studies point out the conflict that exists between how seniors cope with housing and change and how policy makers and planners design systems to address senior housing needs. Essentially, the day-to-day time frame of reference of seniors and their preference to cope on their own is widely divergent from the approach that policy makers adopt for long-term planning, which emphasizes design compensations for physical impairments and concomitantly fails to attend to other coping adjustments. The consequences, argue these researchers, are policies that stress intervention, design changes and service delivery that do not merge well, and in many ways clash, with the strategies devised by senior to cope with the problems of aging (Filion, et al. 1992, 22). To remedy the mismatch between policies and senior preferences, these researchers implore that alternative housing options should be regeared to produce rapid responses, since most seniors only consider housing options in crisis situations, such as the advent of hospitalization or as an alternative to nursing home placement (Filion 1992, 26). Also, they advocate a shift to more outreach and education about community service and design options. Finally, they contend that policy makers should organize all planning and intervention activities according to the ways that seniors actually function, cope, and make decisions (Filion 1992, 27).

The preliminary research presented in this report should help with efforts to follow these recommendations. Also, the overwhelming preference by seniors to age in place fits well with SDRP objectives to concentrate land uses in already developed areas (1992). On the other hand, home health care labor shortages and inadequate public funding of necessary services may

preclude aging in place as an option for many seniors, particularly those with few economic resources.

Migration Trends

The Majority Stays Put

Migration trends are important to the planning of future housing, service and infrastructure needs. However, the overwhelming pattern among by seniors to stay in the same home throughout their later year is even more significant. Staying put is closely associated with housing satisfaction and related to: (1) one's socio-economic status; (2) the condition of housing--in particular, the heating system; and, (3) being of older age (Gonyea 1990, 81; Filion 1992, 24; Lawton 1978). It may be logical to conclude that a large percentage of New Jersey's middle- and upper-income home owners who live in good quality, well-heated homes will age in place. Those seniors with fewer resources who live in poorer quality units with inadequate heating are more likely to move.

Although the majority of seniors stay put, it is useful to know, in terms of land use planning, where and why some seniors move. Available migration studies are based on 1980s data and therefore depict past trends. Destinations points of in- and out-of-state migrants have changed over the decades and most likely will continue to do so. In addition, many people migrate more than once in their senior years. Since the kinds of moves seniors make differ based, in part, on age, then migration trends will also reflect aging trends. These studies can, however, serve as a framework for analysis and offer some guidance in forming assumptions and hypotheses to be tested in New Jersey's population distribution models.

Developmental Migration Trends and Location Impacts

Migration models usually are labor force-linked (Longino 1987). Several important demographic differences, however, must be taken into account to anticipate migratory trends among seniors. Most importantly, movements among seniors relate far less to labor force trends than life-events associated with retiring, health and disability status, family ties, and levels of housing satisfaction. Although migration rates vary for different individuals, the points in time when seniors who do relocate usually occur at three thresholds in life: retirement, the onset of moderate disability, and when major and chronic disabilities occur (Litwak, et al. 1987, 260).

Retirement

Individuals who moved at retirement tended to be younger, better off, and married (Litwak in Longino, 1987, 261). They preferred southern climes, retirement communities, nonmetropolitan areas, and leisure- and tourism-oriented settings. In addition, the AARP found that of the seniors aged 55 and over who moved in 1987, 30 percent decided to do so because they desired another location (1990, 29). Eighteen percent moved because their house did not meet their needs, and 16 percent could no longer afford their home. Sixty-three percent moved to another

home in the same city or county and another one fourth to a different city and county in the same state.

Disability

Following retirement, the two points at which seniors usually moved occurred as the need for disability-related personal help arose that could not be provided by friends, neighbors and institutions . As a result, disabled elders often moved closer to their children to receive help that was usually coupled with greater access to service institutions. Therefore, moderate or severe and chronic disabilities strike, seniors are likely to move. Those who move after the onset of disability tended to be widowed females who either moved closer to needed services or to their children who provided them such services. This may be because older disabled men more often had spouses to care for them. Regardless of who moved, however, the overwhelming majority of disability-related moves were local ones (Litwak, et al. 1987, 263).

Services could help disabled seniors to remain in their homes. But, the use of these services was minimal (Litwak 1987). This may be because home-based assistance for more disabled persons was often highly controlled and routinized (with a concomitant loss of autonomy by the recipient) by service delivery organizations in an effort to minimize abuse and improve efficiency (Litwak 1987, 262). Furthermore, as noted above, design changes that could improve the ability of moderately-disabled seniors to remain at home have tended not to be made. Moreover, the economic and physical requirements for assisting a severely and chronically disabled senior often have meant that only someone with a close personal commitment to the person and substantial resources provided services. Alternately, services for these more disabled persons have been delivered by institutions near the person's children, who then engage in oversight and provide more meaningful personalized assistance with frequent visits. The problems of sterile and impersonal services, high service costs, and lack of familiarity with available services and home modifications could be remedied to permit more seniors to remain in their homes through logical, although not politically easy, solutions.

Exceptions to the Rule

Immigrant seniors and seniors who move from nonmetropolitan to metropolitan areas have shown somewhat different trends. Rural seniors are most likely to remain where they are at retirement and then when disability strikes, move to the suburbs or secondarily, to cities, to gain greater access to services and help from offspring (Litwak 1987, 263). Rural seniors without children may move directly to cities to be nearer to social services. In addition, senior immigrants tend to come from developing counties, and do not come at retirement, but rather as their health declines (Litwak 1987, 263). Older immigrants often move in with children and are far more dependent on family networks than formal institutional service delivery systems. In 1980, these immigrants tended to be Hispanic, poor, and widowed, but not disabled (Litwak 1987, 264). Thus rural areas with high concentrations of seniors may experience declines in the percentage of the senior population in the future unless policies and programs are devised to respond to this migration pattern.

Anticipating Future Disability Moves

In the near future, there may be fewer disability-related moves among women with chronic disability. This is because women who will be over 75 in the 1990s were of child-bearing age during the depression-era, when fertility rates were very low. As a result, these women may have fewer children or close relatives upon whom they can depend for help (Schwartz 1988, 179). It is possible these women will remain in their current home and then, when finally necessary because of ill health, move to an institution. In short, disability-related moves take social resources into account more so than do many other kinds of moves.

In summary, most seniors prefer to remain where they are. When they move, it is usually at retirement and the onset of disabilities. Those who move do so because of affordability, more attractive locations, and housing problems. Younger seniors show more flexibility in their moves and are more attracted to leisure-oriented settings. Most who move stay in the same community and state. Finally, family supports become particularly important to the moves of those with chronic disabilities.

Specific National Migration Patterns among Seniors

Between the 1960s and the 1980s, senior migration reached levels previously unknown in the U.S (see Litwak in Longino 1989, 260). Older migrants flowed to new growth centers in the south and west. Interstate mobility remained unchanged and short distance moves by seniors declined (1989, 3, 4). The fastest growth was in long distance moves, which tended to be made more affluent and independent seniors (1989, 4). Importantly, the proportion of seniors who stayed put remained the same over two decades. Generally, the socioeconomic characteristics of movers remained stable, although, consistent with disability research, local moves were made by seniors who, over time, have needed more assistance (1989, 4). Migrants who moved to urban areas have tended to be more dependent, and were more often minorities and the poor (1989, 4). As Florida's and California's attractiveness has declined, the characteristics of in- and out-migrants have become more similar. In addition, as senior migrants aged, they tended to return to their state of origin at an increasing rate over the 1960s and 1970s.

Generally, the rapid migration of seniors to some states boosted local economies, contributed to growth management problems and strained social service and infrastructure systems. Reverse migration tendencies may relax some of these pressures in these states. Return migrants, however, may be much older, and thus are likely to be female, more disabled and dependent, and poor. This may place additional burdens on senior housing facilities, as well as health and social services organizations and families.

Implications of Senior Migration for Policy and Land Use Planning

The research on migration presented here describes general patterns that were manifested in the past. Several historical patterns are particularly relevant for short-run state and community planning. The most obvious pattern is that most people do not move as they age. Furthermore, communities with housing of good quality and without neighborhood deterioration might expect relative stability in their senior populations. Communities with high percentages of

people in similar age brackets may experience more out-migration as some seniors will move at retirement. Likewise, communities with high percentages of seniors approaching 75 plus years of age might expect local moves by these seniors (if SAH is available) and a resultant opening up of family housing units. Communities with an inadequate supply of affordable housing for young families might explore the advantages to everyone of adding SAH to the community.

Return migration of older seniors is more difficult to speculate upon, but we can expect this flow to increase pressure on the senior housing supply and related service systems. In addition, communities with high numbers of inadequate housing units and many poor seniors might expect more instability in their senior populations. Finally, if seniors continue to prefer to age in place, current patterns of housing development will shape the future location of seniors. Strong efforts now to contain sprawl may have the long-term payoff that populations will remain in already built communities, assuming that the appropriate services are made available. An up-to-date study of New Jersey's migration patterns, however, is needed in order to predict with greater certainty the locational behavior of New Jersey's existing and future seniors.

SECTION III

THE IDEAL VERSUS REAL: SENIOR HOUSING SUPPLIES

Senior Housing Facilities

Recently, national market trends in senior housing have shown confusion, risk avoidance, and shake outs among real estate developers and those in the hotel industry who are involved in senior housing (see also Appendix 6, and Fairchild, et al. 1991). Builders of age-segregated senior facilities have not properly responded to the demands of "aging in place" on housing design and operations. In some areas, over-building facilities that have not matched demand cooled what was thought to be a hot market. The results of poor private sector planning have been failed or failing projects, lender losses, and, consequently, in some states, greater regulation of the retirement community industry (Netting and Wilson, in Fairchild, et al. 1991, 163). Builders of private market housing units and other residential facilities must more precisely define their sub-markets, determine which kinds of supportive environments to build, and attend more closely to the health care and social service needs by senior and service industry trends (Fairchild, et al., 1993, 164; Skyes 1993, 568). More careful assessment of needs, trends, and related public policies should help.

Nationally, some providers of senior housing, however, have slowly moved towards providing more supportive housing (see Appendix 6). This is none too soon. Current supplies of various senior housing forms, however, are woefully inadequate and trends do not suggest relief in the short-term. Meeting the rapidly rising demand for specialized housing and housing-linked services in the immediate future (1994-2005) should also be near the top of the senior housing agenda in New Jersey (Winder 1991, 1).

The following describes 11 senior housing forms developed and operated by proprietary, non-profit, and government organizations in the state. Where possible, the number of each of these housing forms in the state is presented. Importantly, the section does not present data on the overwhelming majority of senior households mixed among the general household population in single- and multi-family homes in New Jersey. Demographic trend analysis of state data can cull age group, geographic, tenure, and housing cost patterns for these households.

Housing Alternatives

Facilities that target affluent seniors include relatively new Adult Retirement Communities (RCs), Continuing Care Retirement Communities (CCRCs), and some Multi-Level Facilities (MLFs), such as Homes for the Aged or Full-Service Retirement Communities. Assisted Living Residences (ALRs) are a newer form of senior housing that provides shelter and a combination of needed services. ALRs include Boarding Homes, also known as Board and Care Homes (B&Cs), and new facilities built as ALRs. B&Cs are most often privately-owned and operated, but tend to serve a less affluent population. Personal Care Homes are one of two types of B&C Home. The other type includes most Residential Health Care Facilities (RHCFs). Congregate Housing Apartments (CH) also offer services and are designed as affordable housing. Most often CH is owned and operated by government. Shared Living Residences (SLRs) are relatively new, and thus far, operated by non-profit sponsors. ECHO Housing (EH) and Accessory Apartments (Aas) are usually built by private sub-contractors on owner-occupied properties. Finally, some RHCFs are owned and operated by private and government

organizations and are more medically-oriented and dependent on health-care financing sources as well as client resources.

Retirement Communities

Retirement Communities are planned unit developments designed for affluent independent seniors. In New Jersey, the entrance age is 55 and over. Rcs can consist of single family homes, duplexes, condominiums, or garden apartments for sale and, occasionally, for rent (New Jersey Division on Aging, 1993). Rcs usually provide on-site recreational and social facilities, maintenance services and, sometimes, transportation. The definitions and enumeration of the state's RCs differ across state agencies. The New Jersey Department of Community Affairs (NJDCA) estimated 71 RCs with 59,000 units in 1989 (1990, 137). The New Jersey Division of Housing and Development (NJDoHD) estimated 58,861 RC units in 1990 (1990, 15). The NJDCA's Division on Aging (NJDoA) counted 61,840 units in 89 RCs in 1991 (1991). These developments ranged in size from 31 to over 2,000 units and were most heavily concentrated in Ocean County, and secondarily in Atlantic, Monmouth and Burlington Counties (NJDoA 1993). Forty-four percent of the state's RCs opened before 1980, 47 percent during the 1980s, and 9 percent in 1990 and 1991. These units were sponsored by both for- and not-for-profit organizations.

RC units are expensive. A single person's annual income had to be, at the very lowest $20,000, and more commonly, $25,000 to enter (Winder 1990, 14). Mary Winder (1990) suggests there might be less short-term demand for RCs and but increased long-term demand as baby boomers mature (4,18,20).

Continuing Care Retirement Communities (CCRCs)

CCRCs are living arrangements that include housing, medical and other services, and long-term care at the same site (NJDoA 1993). These typically contain apartments, rooms, assisted living beds or nursing beds. Purchasers of units in CCRCs enter into contracts with owners for long periods based on the level of care the purchaser requires at the time. The services received by each person are specified in the contract. Medical and other health services, meals, transportation, security, housekeeping, linens, and recreational services are usually available. Entrance fees, monthly fees, and, in many cases, other periodic fees are required. Some CCRCs provide services as a package while others are furnished on a fee-for-service basis. New Jersey's CCRCs charged substantial entrance fees that ranged between $30,000 and $200,000 in 1991 (NJDoA 1993). The NJDCA's estimate of CCRC entrance fees was slightly lower at $20,000 to $100,000 (1990, 137).

Counts of New Jersey's CCRCs vary. The NJDCA identified 12 CCRCs with 2,911 units in 1989 (1990, 137). The NJDoHD counted 3,699 CCRC beds (1990, 15). Mary Winder (1990) counted 5,421 CCRC units in 1990 (14). These units could accommodate between 2,396 people who were living in them in 1990 to 8,421 persons if couples had occupied all apartment units. The NJDoA totaled 18 CCRCs with 5,759 units in 1991. One third of the 18 were built and opened during each of three periods; before 1980, during the 1980s, and the early 1990s. Almost all (16) of the 18 developments were sponsored by non-profits.

In New Jersey, CCRCs were still being built in the early 1990s, despite NJDCA estimates of vacancy rates of over 50 percent (Winder 1990, 14). It is difficult to know if these high vacancy rates were due to the small market for very expensive, age-segregated housing, or some other reason. It could be that, given the high cost of these developments, high-income seniors may stay in their homes and buy individualized services as needed. Given the extensive land use impact of large CCRC and RC developments, closer analysis of this niche of the senior housing market is needed.

Multi-Level Facilities (MLFs)

Multi-Level Facilities, also know as Homes for the Aged or Full-Service Retirement Communities, combine independent living, assisted living, and intermediate and/or skilled nursing care, on a rental basis, and on a single site. Unlike CCRCs, these facilities do not usually require large entrance fees or contracts for changing from one level of care to another (NJDoA 1993). The NJDoHD counted 5,678 beds/units in 49 facilities in 1989 (1990, 15). The NJDoA estimated 70 MLFs, that, in general, tended to contain well over 100 units and/or beds (1993). Of these 70 MLFs, 49 opened before 1980, 22 during the 1980s, and 1 in the early 1990s. Thus, MLFs tend to be older facilities. Most os the state's counties have MLFs with Union County having a slightly higher concentration than the rest. More research is required to determine if the present number and location of MLFs are sufficient to meet short-term demand.

Assisted Living Residences (ALR)

ALR facilities include Class B licensed B&Cs that furnish private or shared rooms and baths, meals, and laundry service, and in some cases, personal care and some health services (NJDoA 1993). Class C B&Cs that convert to ALR, also called Personal Care Homes, provide, in addition to the services of Class B's, 24-hour supervision, some personal and financial services, and monitoring of self-administered medication (DoA 1993; Fishman, 1993). Which services are included in the rent and which are purchased separately varies greatly from facility to facility. All B&Cs afford a semi-independent housing option to seniors. B&Cs do not provide the health services offered in RHCFs, but Class C B&Cs provide slightly more supervision than congregate housing units (see below).

In 1991, there were 54 B&Cs in New Jersey of which 40 were sponsored by for-profit and 14 by non-profit organizations. There were 434 Class C rooms or beds and 140 Class B apartments, rooms or beds in 1993. This combined totaling method makes a count of the supply of B&C and ALR housing difficult. Half of all B&C structures were opened before 1980, 25 during the 1980s, and 2 in the early 1990s. Most counties have B&Cs, but there are somewhat larger concentrations in Monmouth, Somerset, and Passaic Counties. The demand for these facilities is high. Recent efforts to increase the supply of very much needed senior housing with services have offered a time-limited opportunity for licensed B&Cs, and RHCFs (see below) to bypass the usual certification of need process and convert into assisted living facilities (Fuller 1994). However, the adequacy of funding for ALR is in question.

Residential Health Care Facilities (RHCFs) are another type of ALR. RHCFs furnish all the services and facilities of the B&Cs, but offer more health maintenance and monitoring services by professional staff. There were 124 RHCFs in the state in 1993 (NJDoA 1993). These are older facilities. One hundred were opened before 1980, 23 during the 1980s, and 1 in the early 1990s. The NJDoHD counted only 103 RHCFs with 3,996 beds in 1989 (1990, 15). Although most counties have some RHCFs, Monmouth and Morris Counties contain higher numbers of RHCFs. Also, in 1989, Atlantic, Gloucester, Hudson, Hunterdon, and Salem Counties had no RHCF beds (NJDoHD 1990). Additional research efforts are required to determine if there is an adequate present and future supply of RHCFs in the appropriate locations for both current and future needs.

While the future demand for the more expensive CCRCs and RCs is uncertain, there is an overwhelming need for additional affordable senior housing with AL- or CH- (see below) type services (also see Appendix 6). In a cross-agency collaboration, the DoA and the Department of Human Services (DHS) have been developing a package of AL services for persons in subsidized housing to age in place (NJDCA 1993). It is unclear how large the funding levels will be, but this program should help somewhat.

Congregate Apartment Housing (CH)

CH is non-institutional multi-unit housing for semi-independent and independent seniors that furnishes community dining and social facilities, at least one hot meal, and some housekeeping services (NJDoA 1993). Personal and transportation services may also be offered. CH offers the "functionally impaired or socially deprived, but not ill elderly," housing and services with the aim of maintaining "independent or semi-independent lifestyles and prevent premature or unnecessary institutionalization" as seniors grow older (Cronin, et al. 1983, 1). The units are usually one-bedroom or efficiency apartments in market-rate and subsidized facilities which, unlike CCRCs, B&Cs, and RHCFs, are unlicensed. Services are provided on a fee-for-service basis or included in the monthly rent. A diverse array of services and a housing staff capable of coordinating the services is required either on-site or nearby. The location and type of services is determined by facility management and, to a large extent, the reimbursing parties. For example, funds received under the federal CHSP (see Appendix 5) mandate that one hot meal be provided in an on-site community room. Adaptive equipment to maintain independent functioning, on the other hand, must be prescribed by physicians who are usually located in health care facilities or private offices to be covered by most private health insurance policies and Medicare and Medicaid.

The literature on CH estimates that 3 million seniors nation-wide were functionally eligible for congregate housing in 1987 (Monk and Kaye 1991, 13). But of all those eligible, only some choose CH. Seniors who move to CH choose a facility based foremost on its location. Also, upper- and middle-income seniors select CH for the service packages offered, lower-income seniors want the decent housing units, and urban seniors appreciate the safe, un-isolated characteristics of CH (Monk and Kaye 1991, 13).

CH, of all forms of senior housing, is considered to be the most needed form of senior housing because of the combination of housing and services that enable more independent living. The

number of seniors who want CH, especially subsidized CH, is expected to rise dramatically throughout the 1990s as young seniors age and become more disabled. Unfortunately, efforts to expand CH, which is already in very low supply, are expected to continue to be thwarted by the political and economic battles that have hampered CH developments thus far (see Appendix 5). These issues will most likely be far more important to the future of subsidized CH in particular than the demographic imperatives. Experts forecast that the future of subsidized CH facility size, location, and associated service sector expansion will hinge on the outcomes of the jurisdictional and political battles over CH (Redfoot and Sloan 1991). In addition, substantive concerns remain over the ability of CH to retain its essential character given demographic and economic tendencies. These concerns include such questions as: (1) What will prevent CH from "institutionalizing," especially in buildings where residents can buy their own services as residents age and the demands for services grow?; and (2) Will more recent trends, such as packaging services and building larger buildings to achieve scale economies, reduce the semi-independent nature of CH that drew (at least middle-income) seniors in the first place? (Monk and Kaye 1991, 17). These changes, coupled with resident preferences and public funding will probably determine the number, location, size, and footprint of future CH facilities.

Congregate Housing in New Jersey: Private market CH in the state includes rental and owner-occupied units. One facility is operated by a non-profit organization. There are currently 5 private CH facilities in the state with approximately 1,088 units (NJDoA 1991, 1993). In addition, some subsidized senior housing buildings (see Subsidized Senior Apartments below) provide supportive environments similar to those offered in CH by providing equivalent services. This division makes consistent total counts of the state's CH difficult. Senior Citizen Apartments numbered 60 in 1991 (NJDoA 1993). Most of these units were funded by state and local governments and 8 buildings received federal aid for services. The NJDCA estimates of CH are higher, counting just 14 "fully" CH facilities with 2,300 units and 70 buildings and more than 10,000 units that provided meals and housekeeping services under the state CHSP program in 1989 (1990, 138). Moreover, the NJDoHD counted 2,291 CH units in 14 buildings in 1989 (1990, 15). Some data suggests that the geographic distribution of these units is uneven. The NJDoHD (1989) counted no units in Atlantic, Cape May, Cumberland, Gloucester, Hunterdon, Morris, Salem, Sussex, Union, and Warren Counties (1990).

There is a critical need to expand case management in CH for frail seniors (NJDCA 1991). While NJDCA programs aim to increase CH, available resources will not relieve the great shortage in the near term. For example, the NJDCA received a federal Department of Housing and Urban Development (HUD) grant through the HOPE for Elderly Independence Demonstration Program to help 70 frail senior persons in a 5 year demonstration program to use vouchers for housing and community-based services. The program's goal is to prevent premature or unnecessary institutionalization (NJDCA 1993). Other plans include adding services to subsidized buildings, thereby converting these buildings into assisted living facilities (Fuller 1994).

Senior Apartments (Subsidized)

A thorough and fairly recent study conducted under the auspices of the NJDCA and NJDoA gauges the supply of and demand for subsidized senior housing in the state (see Appendix 7) (Hughes and Miller, 1993). The study analyzed the characteristics of buildings, project staff, services provided, waiting lists (as an indicator of demand), planning and construction of new projects, and building sponsorship and management.

Senior subsidized housing, which serves both seniors and the disabled adult population, numbered 54,774 units in 446 buildings in 1991, reflecting considerable additions since an earlier survey in 1973 (Hughes and Miller, 1993). This number differs somewhat from the NJDoA count of 52,259 units in 425 facilities (NJDoA 1991). Regardless of the precise number of buildings and units, the most significant trend was the "drastic slowdown in the pace of construction" since 1984 (Hughes and Miller 1993). Based on current construction patterns, the authors expected only a slight increase in the number of senior subsidized housing units in the future. Demand was estimated by waiting list turnover time. There was a 9-year turnover period statewide with county rates ranging from 6 months in Warren to about 25 years in Middlesex. More detailed findings excerpted from the study, including geographic analysis, are presented in Appendix 7.

Shared Living Residences (SLRs)

Definitions of SLRs vary. In the broadest sense, they are residences shared by unrelated people (Pollack 1991, 3). Single parents sharing their home with a paid child care worker or senior, homes for the disabled, and many student rental units would fall within this definition. In New Jersey, SLRs are defined narrowly, and usually consist of several people sharing a home owned or leased by a non-profit organization or cooperative, in which all the rooms are shared except for private bedrooms (NJDoA 1993). Usually, a volunteer or paid manager offers supervision. Using this definition, there were only 14 recognized SLRs in 1993, 5 of which were in Bergen County. These SLRs usually accommodated about 5 persons. The NJDoHD estimated 124 SLRs in 1989, half of which were in Bergen County (1990, Table H). More research is required to determine why so few SLRs exist in the state and why 1 county is more highly represented than others.

Like other housing alternatives for seniors, those who rehabilitate their homes into SLRs may benefit from several sorts of advantages: (1) financial, such as increased income for living expenses, home maintenance, and taxes; (2) social, such as companionship and a more diversified neighborhood; and (3) personal, such as security and services. These advantages of SLR living may enable some seniors to remain in their homes (Pollack 1991, 4). Patricia Pollack (1991) describes the benefits to the community as "the enriching experience of multi-generational neighborhoods for those who prefer [this]," "increased neighborhood stability including a steady demand for community services," and "reduced strain on formal services such as community-based senior services and nursing homes," "efficient use of housing stock," "increased property maintenance [and thus] property values" (4).

Accessory Apartments (AAs)

Accessory Apartments are separate apartments within a single-family dwelling (Hedges 1991a, 3). AAs may, but do not necessarily, share yards, garages, and parking with the main home. AAs are used by any household that requires a small living space. Some estimates of AAs ability to increase the affordable housing stock have been as high as a 14 percent if these units were legalized nationwide. HUD has supported AAs as an "easy and relatively inexpensive strategy for increasing the amount of affordable housing" (Hedges 1991a, 3). Similarly, the AARP contended that AAs could more efficiently use single family housing and, for low cost, add to the stock of small rental units that are in short supply in many locations (Hedges 1991a, 3). Nationally, the average cost of constructing an AA was $16,500 in 1991 (Hedges 1991a, 3).

Most discussions about the potential supply of AAs begin with references to the "overhousing" of America's seniors (Hedges, 1991a, 3). AAs have been promoted as capable of solving some of the housing problems of senior homeowners by providing security, income, personal services, and opportunities for social contact and support. Primary household owners of AAs, for example, could earn at least $1,500 in income (Hedges 1991a, 3).

Despite the many attractive characteristics of AAs, legal barriers in zoning ordinances and restrictive covenants prevent their use in many communities. Opposition to AAs has often stemmed from fear that AAs will proliferate throughout single family neighborhoods, changing the character of neighborhoods, increasing densities, and straining government services and parking space. Most of these concerns have been adequately managed in local zoning code revisions that define the conditions under which AAs may be built (see Hedges 1991a, 4-8). In general, communities that have been the most successful in facilitating AA development and addressing neighborhood concerns have incorporated: (1) "age inclusive zoning" in the housing elements of master plans; (2) clarified the meaning of terms such as "one residence," "residential purposes," and "primary or principle residence;" (3) designed special exceptions, required home owner residence in the AA or the primary unit, and limited exterior structural changes; (4) imposed conversion rate and area controls; and, (5) implemented procedures for neighborhood review of AA applications (Hedges 1991a, 8).

Elder Cottage Housing Option (ECHO)

These units afford seniors and persons with disabilities independent living in close proximity to people who offer the senior support (Hedges 1991). ECHO units are small, removable, manufactured modules affixed to concrete slabs in the back or side yards of a house. Thus far, there are 7 ECHO units in New Jersey, 3 of which opened in 1988 and 4 in 1990. All of these units are in Warren and Hunterdon Counties.

Nationally, ECHO units are very cost-effective housing, with an average cost in 1987 of $26,635 for purchase and installation (Hedges 1991, 1). And, like AAs, these units have been touted as a way to increase substantially the income of the senior owning the primary unit by adding an ECHO unit to their property and then selling the home while moving into the unit. In many communities, however, ECHO units have been opposed. Fears that ECHO units will not be removed when the occupant moves or dies, and concerns about parking, density, and the

development precedences set by approving ECHO units have been the main obstacles. Zoning regulations against temporary structures and "mobile" units and restrictive covenants have been used to deter the development of ECHO units. Moreover, state regulations and local laws, in general, tend to limit manufactured housing despite substantial form and quality differences that have made ECHO units similar to conventional housing in quality, appearance, livability, and durability (Hedges 1991, 4).

Some states and communities have taken steps, similar to those taken for AAs, to make ECHO options more possible. Age inclusive provisions in local housing elements or master plans, design criteria in state, county and local zoning ordinances, and clarifications of the meaning of mobile home, temporary structure, and manufactured housing in state and local ordinances have helped states and localities increase ECHO units (Hedges 1991, 4-6). The more successful measures have been: (1) clearly defined ECHO units as movable but not mobile; (2) specifying ECHOs as only for older persons with disabilities; (3) granting only special or conditional use permits; and (4) requiring a bond be posted by the primary homeowner that state, when the ECHO use is terminated, the unit must be removed (Hedges 1991, 7-8). In addition, offering technical assistance stimulates the usage of ECHO units (Gonyea 1990).

Institutions

Intermediate Care Facilities (ICFs) and Skilled Nursing Facilities (SNFs) are both Nursing Homes, each providing different levels of care and are licensed by the New Jersey Department of Health (NJDoH). ICFs are sometimes chosen as a last resort because of the alternative available for those with great in-home services needs. These home services are sometimes more expensive and more difficult for families to oversee than is institutional care (Mitchler and Burr 1991, 377). Frequently ICFS are chosen by either seniors of considerable income and wealth or the very poor. Generally speaking, the more affluent can afford to modify their homes for more independent functioning, or purchase beds in the more exclusive ICFs. Poor seniors move to facilities subsidized by the state when a room or bed is available. State policies can protect the home equity of seniors from being used to pay ICF care so that household members are not penalized because of a senior's ill health (Mitchler and Burr 1991, 377). In states requiring seniors to spend their resources before being eligible for ICF care, middle-income seniors tend to first become low-income seniors, and then receive publicly-subsidized nursing home care.

In summary, a confusing array of senior residential alternatives exist. These are generally categorized by level of services, amount of health-related care, and cost and subsidy. While counts of residential types vary, and current and future demand is hard to predict, initial data suggest the following trends: (1) in the up-scale market, RCs, and CCRCs appear to be in oversupply; (2) affordable units, especially those that provide services, are vastly undersupplied; (3) recent inter-agency efforts and trends in private sector developments suggest that supportive-style AL environments with services are being added, but these are very limited in number and nowhere near the level of demand; (4) the supply of subsidized and private market senior housing and/or services is not expected to rise much in the near future, given jurisdictional battles over budgeting and the elimination of a variety of financial incentives to developers (see below page 59); and, (5) some of the more innovative alternatives

such as AAs, ECHO units, and SLRs, although attractive, continue to be little more than demonstration projects.

More detailed demographic studies could reveal the size of the eligible population for each of these residential types. All facilities licensed by New Jersey's state agencies have minimum requirements for unit sizes, services, and facilities. This source can be used to estimate future building footprints and estimating needed facilities.

SECTION IV

SERVICES and HOUSING FINANCING and POLICIES

Services: Housing Choice Factor #3

Some experts on senior citizen housing issues argue that any discussion of senior housing cannot be considered separately from senior services (Fuller 1994; Pastalan 1990). Services relate directly to senior housing decisions because many seniors with health problems and disabilities require services to live in particular housing arrangements. The cost of, access to, and types of services available, in conjunction with housing arrangements, in large part, determine what housing options are available to seniors. Service availability, particularly community-based services, however, is one of the most troublesome areas in senior housing. This concern stems from a number of problems including: fragmented delivery systems; declining or fluctuating service funding; the uncertainties of health industry consolidation, cost containment efforts, and health legislative reform; inadequate service labor pools; and the high cost of personal and health services.

Fragmentation

There is an urgent need for more integrated housing and community services for seniors (Pastalan 1990; NJDCA 1991). Efforts to coordinate housing and services are frustrated in most states because the agencies responsible for pertinent activities are separate and operate with diverse responsibilities, priorities, and divergent policy directions (Pastalan 1990; Fuller 1994).

Unpredictability in Services Funding and Policies

Since the 1980s, health and social services have been dramatically transformed by public policy and industrial transformation. Some analysts contend that these forces have acted as a catalyst for health care industry consolidation, the loss of less competitive community-based providers, and a proliferation of large managed care systems. For example, locally-based community services for seniors have been reduced because of the privatization of the more profitable health and social services, health care industry consolidation and bureaucratization, and a more fragmented service delivery system (Estes 1993, 294). These shifts have also narrowed access to health care for the poor and for some racial groups, reduced services deemed unprofitable by managed care systems, and enabled industry lobbying to whittle away the tax status of non-profit providers. Since the majority of local community health services are delivered by non-profits, this outcome would diminish the ability of seniors to receive community-based services, and for those at risk, to remain in their homes (Estes 1993, 294). Also, community services have witnessed absolute declines in funding levels. Indirect community services, in particular, such as case management and assessments, although billed as a cost containment measures, have received much less funding over time (Estes 1993, 292, 296). These events have led some New Jersey authorities to contend that a "critical need for expanded case management for the frail elderly". . .[and] "home health care, home repair, and transportation" exists in the state (NJDCA 1991, 145). Should there be no change in funding priorities, the most obvious result might be pre-mature institutionalization of vulnerable seniors, greater transportation costs and effort borne by seniors to locate appropriate services, greater strain on working families to provide unavailable services to their parents, and for some seniors, living without needed care.

What is more, at the same time that community and indirect service expenditures have been reduced, direct (institution-based) medical care expenditures tripled (Estes 1993,292). Also, Medicare and Medicaid, the health service payment systems for the elderly, the disabled, and the poor, favor the use of institution-based medical and long-term nursing home care over community-based care. For example, in New Jersey, it has been estimated that about $900 million in Medicaid expenditures were nursing home and community-based health services in 1993 (N.J. Division on Aging 1993). Of this, 9.3 percent went to community-based services while 90.7 percent was spent on nursing home care. It is clear, then, that national government expenditures are biased towards nursing home care. In addition, these programs, as well as most private insurance packages promote acute care services over rehabilitation, environmental adaptations, and chronic care and supportive care (Estes 1993). In these ways, the services that facilitate independent or supported living arrangements among seniors through community-based systems are limited by policy and funding biases.

Land Use Impacts

These spending biases have clear spatial dimensions. Medical expenditures supported the dramatic expansion of large, direct medical service delivery sites, research facilities and related structures in recent years (Estes 1993, 292). In some localities, hospital and medical research center expansion has been a central thrust of economic development efforts and added substantially to the urban infrastructure. Also, communities with high concentrations of seniors have taken advantage of federal funds to construct senior centers that often provide service referral, transportation to appointments and shopping, and recreation. Moreover, as discussed above, when seniors move, many move to locations that offer good access to services. Seniors select neighborhoods and communities with access to medical facilities and doctor's offices. Conversely, services are developed in places with high concentrations of seniors. In short, public policy, health and service industrial change, and cultural preferences, converge to shape the location of seniors and related facilities.

These spatial ramifications of health care industrial change and community-based versus large institution-based services have received little attention in the battles over health care policy and financing reform, but with or without reforms, the future of health service delivery is certain to be extremely volatile (Estes 1993, 295-296). Uncertainty over health and social services delivery and financing will continue throughout the 1990s. And, the demographic, economic, and land use impacts of policy and industrial developments merit close and constant attention.

Housing Finance and Policies

Barriers to New Senior Housing Construction

The high cost of construction has limited new market-rate and subsidized senior housing (Early 1989, 53). Mary Early (1989) examines housing finance trends that have curtailed development of senior housing units. First, FHA low-interest mortgages have declined, reducing the ability of developers to build financially viable projects (63). Second, rent subsidies for low-income senior projects have been cut back at the same time that the eligible population has grown. Third, the failures of some retirement communities reduced bank lending for RCs. Finally, the

loss of tax-exempt bond financing eliminated a substantial funding source for developers. For example, The 1986 Tax Reform Act reduced the attractiveness to developers of entering into cooperative housing agreements with states (Schwartz 1988, 187).

As financing sources have dried up, senior housing developers have relied more heavily on conventional mortgages, taxable bonds, credit enhancements, other forms of mortgage insurance, syndication, and assistance from investment bankers to a greater extent to finance their projects (Early 1989, 64). Still, many developers cannot assemble viable financing packages. What is more, many of these financing tools are quite complex, and require more capital to be spent on expensive consultant services (Early 1989, 64). There is little in the near term that suggests additional incentives to develop senior housing will be forthcoming.

Innovations in Housing Finance

At the same time that incentives to developers of senior housing dwindled, financial tools that aimed to give seniors more flexibility in using their economic resources for mainstream housing forms have been developed. These instruments were a response to arguments that seniors have large equity in their homes but low annual incomes, thereby limiting their ability to meet expenses and discouraging many from aging in place. For example, after age 75, most of the income sources discussed in Section I taper off to the point where they no longer can support seniors (Schwartz 1988, 189). Equity conversion programs work by allowing seniors to extend their lifetime income by borrowing money from the value they have invested in their homes. The main programs include reverse mortgages, sale/leasebacks, guaranteed first and second mortgages, lines of credit, and split equity arrangements.

Reverse Mortgages (RMs)

These mortgages, initiated in the early 1980s, permit home owners to borrow from their home equity (usually up to 80 percent of value and not more than a specified amount) either for fixed monthly cash payments or payments in combination with a larger up-front sum used for home repairs or to purchase income annuities (Schwartz 1988, 190). Upon death, the mortgage becomes due and inheritances are reduced by the value of the mortgage.

Sale/Leasebacks (S/Ls) and Split Equity Arrangements

These tools have had a much longer trial period and come in many shapes and sizes. Most commonly, investors such as a financial institution, a private investor, or a family member, buy a senior's home, and then lease it back to the senior at a specific monthly rate. The senior receives the benefits of additional income from the sale either in a lump sum or through annuity or mortgage payments.

Another tool, similar to the S/L, is the split equity arrangement (Schwartz 1988, 192). Split equity programs allow seniors to retain partial equity in their home and lifetime tenancy. The purchaser makes an initial and partial lump sum equity payment followed by monthly installments to the senior owner with the intent of eventually owning the home entirely.

Deferred Payment Loan Programs (DPLs)

Several states have initiated DPLs with loans made for home repairs, maintenance, to prepare a home for sale, or to create income-producing units such as AAs (Schwartz 1988, 192). Typically, the loan is not repaid until a later date or when the home is sold.

Tax Deferral Programs

Tax deferral and relief programs have been developed in some states and localities to help seniors manage housing costs. The growth of these programs, however, has been very slow (Gibler and Rabianski 1992, 567). The utility of such programs to New Jersey's communities and the resultant land use impacts requires further research.

The Limitations of New Housing Finance Tools

Numerous problems with equity conversion programs exist (see Schwartz 1988; Case and Schnare 1994). On the supply side, unfamiliarity means substantially more resources and procedures are used to take advantage of them. Regulations require counseling programs to help consumers evaluate program benefits, which, although beneficial to seniors, add costs to lenders. Also, unless the loan is insured by the FHA or another insurer, only the property value backs the mortgages. Additionally, FHA reverse loan origination time takes longer than origination of FHA's conventional forward mortgages. In addition, flexible payment plans create unstable revenue streams and increase costs to lenders. Furthermore, maintenance incentives to home owners are reduced as equity is transferred to the lender / purchaser. What is more, interest rates for these programs are high because of higher risks, the small size of the market, and because resale, securitization, and derivative markets, all of which are well developed for forward mortgages, have not yet developed for the newer tools (Case and Schnare 1994).

In some states, equity conversion programs continue to be little more than demonstration projects or have characteristics that discourage public interest (see Schwartz 1988). For example, in many states, mortgage holders or investors have no obligation to allow the senior to remain in the home. Some states allow equity holders to keep the remaining home equity should the senior move, die, or not use the full value of the loan. And, there are no federal standards for equity conversion programs. As a result, even more legal and financial sophistication is required by seniors to utilize these already complex tools.

Interest Is Limited

Despite some research that suggests that 25 percent of low-income seniors and 40 percent of homeowners over age 75 could increase their income above the poverty line through equity conversion, few seniors have been interested in these programs (Schwartz 1988, 189). Based on 1970s data in the Retirement History Survey, it was ascertained that most seniors did not want to convert equity to cash (Gibler and Rabianski 1992, 567). Venti and Wise (1992) also found that home owners with large home equity but low income tended to reduce their equity, while those with low equity and high income increased their housing wealth (cited in Gibler and

Rabianski 1992, 567). And, most seniors who moved tended to augment rather than decrease their home equity. Furthermore, when assets have been spent down for expenditures, seniors preferred to retain home equity assets. In addition, in some states, the protection of home equity in the event of large medical bills or nursing home care served to reinforce decisions to hold onto home equity (Mitchler and Burr 1991, 377). Moreover, the minimal use of conversion programs has been attributed to senior expectations of a long life, large future medical expenses, plans to give an inheritance to their heirs, and their preferences for a thrifty retirement lifestyle (Venti and Wise 1989 in Gibler and Rabianski 1992, 567; Schwartz 1988, 191). Studies using somewhat more recent data confirmed these findings. In a 1986 AARP survey, seniors ready to move earned higher incomes, possessed lower equity, were young, lived alone, or were seriously ill (in Gibler and Rabianski 1992, 567). Age, sex and spending and saving practices, however, were found not to be significant to interest in home equity conversion programs according to Karen Gibler and Joseph Rabianski (1993, 583). The more significant factors were a low house value (less than $50,000) and a desire to live independently (1993, 583). These authors speculated that the low-value homes were in disrepair and located in declining neighborhoods, eliciting little lender interest in advancing substantial funds for repairs. Also, seniors with substantial home equity who face institutionalization may use their equity to purchase home-based health and personal care services (1993, 584).

As public awareness of equity conversion programs has increased, and as programs have been refined to permit seniors to remain in their homes, public interest in these tools has improved slightly. Three surveys of senior interest in equity conversion in the 1970s and early 1980s concluded that the most interest is found among the more financially needy seniors and younger seniors (Federal Home Loan Bank Board, Nelson, and AARP cited in Gibler and Rabianski 1992,569). Actual participants in equity conversion programs, however, have tended to be older, poorer and with substantial home equity or single women with minimal home equity (Gibler and Rabianski 1992, 569-570).

Potential New Markets

Other researchers believe that there may be many more potential users of equity conversion programs than earlier research has claimed. Sally Merrill, et al. (1994), using 1985 to 1988 American Housing Survey data (see Appendix 1), identified the 800,000 seniors with incomes under $30,000, and home equity between $100,000 and $200,000 who have lived in the same home for over 10 year as the prime target market for reverse mortgages (257). They note that likely markets exist in areas with large numbers of seniors who have low incomes and high equity; these are most notably in suburbs (283). In addition, the New York and Philadelphia SMSAs are regional target markets given their high percentages of older seniors with specific equity / income balances (282-290). Similarly, using SIPP data, other researchers found that higher income seniors, those with large debts, and childless seniors were also market pools for these programs (Mayer and Simmons 1994, 253-254).

The future popularity of conversion programs is anything but clear. Although interest in conversion programs has been low, as defects in many conversion instruments have been winnowed out and lenders have become more comfortable with risk calculation and processing, interest has picked up. Together with research identifying large potential markets

in the New York and Philadelphia SMSAs, these developments may signal growing viability of equity conversion programs as an option for some of New Jersey's home owning seniors.

New Jersey Housing and Service Programs

New Jersey offers a broad array of senior housing and service programs (see Appendix 8). These programs are administered by a multiplicity of state, county, and local agencies, including, but not limited to: The New Jersey Division on Aging, The Housing and Mortgage Finance Agency, and The Division of Housing and Development, all of which are part of the NJDCA; The New Jersey Department of Health; The New Jersey Department of Treasury; Area Agencies on Aging; and the Housing Authority of Bergen County. Also, municipalities offer a variety of programs. Finally, some private lending institutions in the state offer equity conversion programs.

APPENDICES

APPENDIX 1

Who Are Senior Citizens?

It is useful to reach a common understanding of just who a senior citizens are before discussing the most salient factors that shape housing and service decisions made by senior citizens. In part, the answer to this question depends on who is asked. Mature persons, making age-related lifestyle decisions such as when to retire, or whether to work part-time, whether to modify their homes, move, or whether to hire personal and home help are of many ages. These choices are influenced by such diverse factors as one's health, both personal, and that of family members, the severity of disabilities, amounts of accumulated savings and investments, the character of the neighborhood, and employer retirement plans. Despite variations in the ages at which people make these critical life decisions, public policies and scholarly research formulate standardized age limits and age criteria in order to: (1) achieve uniformity and fairness when delivering public services and programs; (2) establish comparable categories across the elderly population for comparative research purposes; and (3) for convenience.

Age limits are used by convention to identify senior citizens and senior subgroups. Most definitions employ age cutoff points for seniors as persons age 60 and over (60 plus) or age 65 and over (65 plus). The usage of these cut-off points is rooted in the history of public policies and their associated programs. The Older Americans Act of 1965 establishes 60 plus as a service age group. The Social Security Act of 1935 and the Medicare and Medicaid Acts of 1965 sets 65 as the lowest age limit for collecting Social Security and Medicare benefits. These age limits continue to serve as eligibility criteria for these and many other government programs. In addition, census data are frequently used to describe the senior population and its subgroups. The data are summed into age groups or cohorts. The most frequently used cohorts are ages 65-74, 75 and over, and 85 and over. Also, smaller health and disability related national surveys (see Appendix 1) use different age cohorts, with seniors often classified as those over 55 years old. In addition, the age 65 has been ingrained into the American psyche as the age of retirement. This has changed somewhat in recent years with the advent of early retirement, workers in particular fields who continue to work full-time in their present jobs well after age 70, and seniors who retire and then move into new and different jobs. Nonetheless, many of these decisions as well as firm retirement policies, are made in reference to age 65, in part, because of the age-triggers of the above mentioned public policies and programs. In short, public policies, data collection methods, and common practice combine to make age 65 and over the most commonly used indicator that someone is a senior citizen.

In addition to age references, discussions about seniors employ several terms to label the total senior group and its subgroups. The elderly, the aged, seniors, and senior citizens are the most common appellations for the whole senior group and tend to refer to persons age 65 and over. However, the terms the young-old, the active elderly, and the newly retired are frequently used to refer to persons anywhere between 55 and 65. Young seniors usually refer to the 65-to-74-year-old group. Mature seniors, the old, the oldest old, and the frail elderly are the most prevalent terms used in identifying persons age 75 and above. This group is often given special attention because, of all senior persons, people in this age group have greater need for social

and health services, income supports, different housing forms, and are at higher risk of institutionalization.

APPENDIX 2

Resources Useful to Further Study

American Housing Survey. Bureau of the Census. Called the Annual Housing Survey prior to 1984. These are surveys of housing units in the nation and in selected metropolitan areas. The data is available in the National Core file and the National Core and Supplement file. National file questions are consistent and supplement file questions vary from year to year. Also, transportation data is accessible in the Travel-to-Work file.

Annual Housing Survey files contain data on housing and neighborhood conditions, but the former may not completely reflect all the conditions needed for frail seniors to remain living in a home. Other useful information includes comparative costs of housing in geographic areas over time, costs for mortgages, rents, real estate taxes, value, utilities and insurance, and adequacy of neighborhood facilities and services. Income data included in the files can be used to calculate percentages of income spent on housing. Also, last year moving behavior is described including influential factors. Age, sex, race, marital status, income, household relationship, eduction, and tenure variables are incorporated. The same housing units are included in repeated years, allowing longitudinal studies from 1974-1983 and 1984-onward. National surveys have been conducted every two years after 1981. Metropolitan surveys are carried out on 20 selected SMSAs and 44 MSAs on a rotating basis, with 11 surveys conducted each year and any single MSA surveyed every 4 years.

Transportation files include work destination, time, distance, and mode variables for all household members who held a job at the time of the survey.

Current Population Survey (CPS) Series. Bureau of the Census. A monthly survey of households that includes variables on characteristics of the labor force, employment and unemployment, occupation, and industry; and a variety of demographic characteristics such as age, sex, income, race, martial status, household relationship. The survey entails a set of core, or repeated questions and supplemental or occasional questions. Many supplemental series have titles reflecting their subject matter. The 1983 CPS covers retirement and pension plan coverage including IRAs and Keogh plans.

Gordon, Paul A. 1988. Developing Retirement Facilities. New York: John Wiley and Sons.

Inter-University Consortium on Political and Social Research. 1993. Inter-University Consortium on Political and Social Research Guide to Resources and Services, 1991-1992. See this guide for detailed abstracts of some of the surveys and data sources listed on this page and many more. The Guide includes a full section on Aging and also lists data set sizes, formats, file structures, cases, variables, and records.

Inventory of Long-Term Care Places, 1986. National Center for Health Statistics. Data includes type of ownership, number of beds, age group served, types of persons served, descriptions (skilled nursing, intermediate care, licensed but not certified, long-term care wing of a hospital, foster home, related care facility).

Kasprzyk, Daniel, Patricia Doyle, Arthur Goldstein, and David B. Manton, Kenneth. G. 1992. The Dynamics of Population Aging: Demography and Policy Analysis. Milbank Quarterly. 69: 309-338.

McMillen. 1987. Survey of Income and Program Participation User's Guide. Washington, D.C.: U.S. Bureau of Census. National Center for Home Equity Conversion.

National Health Interview Survey: Cumulative Core File; Longitudinal Study of Aging (LSOA), 70 Years and Over, 1984-1989. National Center Health Statistics. The LSOA is designed to provide mortality rates by demographic, social, economic, and health characteristics unobtainable from the vital statistics system. The LSOA also measures change in the functional status and living arrangements of seniors, and gauges the use of health care services. Noninstitutionalized persons age 55 and over are included.

National Hospital Discharge Survey Series. National Center for Health Statistics. The surveys have been conducted annually since 1977. State-level data is available for short-stay (average length of stay under 30 days) hospitals, or general and children's hospitals. Demographic variables include age, race, martial status, status at discharge, diagnosis, and sources of payment. Hospital characteristics include such as bedsize, ownership, and geographic region.

National Long-Term Care Survey, 1982-1984. U.S. Department of Health and Human Services. Office of Assistant Secretary for Planning and Evaluation, and the Health Care Financing Administration. The survey was designed to provide a basis of describing the chronically disabled elderly population. Data is available on health and functional status, patterns of use of Medicare, hospital care, home health services, and institutional care. Information is included on the kinds and costs of services, the ability of persons and families to pay for care, and the number and characteristics of persons not receiving care. Caregivers information is also included such as expense and time costs, mobility and work restrictions due to caretaking, and kinds of care provided.

National Medical Expenditure Survey, 1987: Household Survey I, Population and Home Health Providers. Agency for Health Care Policy and Research. A two part survey of health conditions, disabilities, and the use of assistance, facilities, and services such as special transportation, home delivered and congregate meals, home care, special equipment, adult day care centers, and senior centers. Persons with public and private health insurance are covered by the survey. Demographic characteristics include age, which is divided into groups 55-64, 65-74, 75-84 and 85+. Geographic references are not available. Part II covers providers of services and includes variables such as type of service, provider's place of work, specialty, and relationship to the recipient (or lack thereof).

National Nursing Home Survey, 1977, 1985. National Center for Health Statistics. Data are available on characteristics of residents such as age, place of residence prior to admission, martial status, health status, services received, and outcomes. Facility characteristics include size, ownership, occupancy rate, days of care provided, certification.

Simonsen, William. 1994. Aging Population and City Spending. Journal of Urban Affairs. 16(2):125-140.

Soldo, Beth J. and Kenneth Manton. 1985. Changes in Health Status and Service Needs of the Oldest Old: Current and Future Trends. Milbank Memorial Fund Quarterly. 63:286-23.

Survey of Housing Adjustments. 1979. A data set within the American Housing Survey developed jointly by the Bureau of Census and the U.S. Department of Housing and Urban Development. Survey to evaluate life adjustments in household operation, household consumption, and health-related activities undertaken for more independent functioning.

Survey of Income and Program Participation (SIPP), 1984 and 1988. Household Economic Studies Series P-70. U.S. Bureau of Census. Evaluates economic status and government program participation. The series presents survey results.

Przybylski, M. 1991. Uses of the National Medical Expenditure Survey for Planning Agency Services. Indianapolis: Heartland Center on Aging, Disability and Long Term Care, Indiana University.

APPENDIX 3

Disabilities: Definitions and Legislation

Legislation

The Americans with Disabilities Act of 1990 (ADA) extended civil rights protection to disabled persons. In terms of housing choices, owners and agents cannot discriminate against persons with disabilities, and communities and building owners are required to make reasonable changes to buildings and infrastructure to make facilities accessible to disabled persons. As of July 1994, all public facilities and large and small firms must be in compliance with the law.

What is a Disability?

In the past, disease and health conditions were often used as proxies for disability measures. The presence of disease, however, does not equate functional disability. A disability is the inability to perform a specific task of daily life. These tasks are divided into Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). Essentially, the difference between the two concerns the ability to care for personal physical needs, or ADLs (bathing, toileting, dressing, and feeding, and transferring oneself from a bed or a chair, and walking) and the tasks one must do to live independently, or IADLS (light housekeeping, shopping for personal items, meal preparation, managing money, and using the telephone and transportation) (Golant 1992, 33). The more impairments one has in these two categories, particularly the former, the more dependent the person is considered to be.

Disability Definitions in Data Sources

A disability is defined differently in the various data sources. The term "disabled" in census documents refers to persons who identified themselves as having a mobility limitation and/or a self-care limitation in 1990 in relation to their ability to work and/or use public transportation. For example, the term does not include persons without work or transportation limitations who have disabilities that manifest themselves in other ways (Pfeiffer 1993, 729). Many major health and disability survey instruments, such as The National Long Term Care Survey (based on Medicare records), The National Medical Expenditure Survey, and The OARS Assessment, count the number of impairments in ADLs and IADLs. These surveys are more discrete and conducted more often than the census. Population variables include, for examples, age, sex, income, disease type, geographic location, disability level, and level of care.

Disability Benefits and Seniors

Working age persons with work-related disabilities who are under age 65 are eligible for disability benefits. Although seniors are not eligible to collect Disability benefits per se, adults who are or become work-disabled, upon reaching age 65, can collect payments from the SUPPLEMENTAL SECURITY INCOME (S.S.I.) Program. Unlike disability benefits, however, S.S.I. benefits may be reduced by the value of other entitlements collected by a senior (New Jersey State Bar Foundation 1992).

Disabilities and Land Use Planning

Disability data and trends are useful in projecting senior housing needs. For example, the need for long-term care and other residential facilities and various types of community health services can be projected based on this data. Analyzing the geographic concentration of disabled senior populations can help communities to comply with the ADA, determine what kinds of facilities, infrastructure modifications, and housing types are and will be most needed in the community. Furthermore, thorough assessments of disabled populations in New Jersey may help to better direct intergovernmental aid to the appropriate communities.

APPENDIX 4

Preferences for Housing with Services: A Summary of Three Studies

Study 1: Preferences for Service Assisted Housing (SAH)

SAH is housing for independent, healthy persons ages 60 and over, that consists of moderately-priced rental apartments in multi-unit complexes. These units have no entrance fee, no continuum of care, are "linked to flexible levels of supportive services, personal care and minimal health services that are provided as needed, on a fee-for-service basis, and are coordinated through the housing provider" (Granger and Kaye 1991, 60). In a study of Pennsylvania's seniors (60 plus), Granger and Kaye (1991) found that 28 percent of the state's healthy, middle-income respondents were interested in relocating to housing with services. Ineligible for subsidized housing, and with insufficient resources for retirement communities, this population was viewed as underserved in the state.

Three-quarters of study respondents preferred to live outside central cities, 37 percent favored suburbs and 36 percent wanted a small town (65). Older urban and suburban dwellers were very receptive to renting SAH, while rural and small town residents preferred to own their units (72). Sixty-one percent of respondents wanted two-bedroom units, 30 percent preferred one-bedroom, and 6 percent opted for studio units. Of those expecting to live alone, 46 percent favored one-bedroom units and 38 percent fancied two-bedroom units. Of two-person households, 30 percent favored one bedroom units and 41 percent fancied two bedroom units (65). One third preferred low-rise buildings, but two-thirds would be satisfied with either low- or high-rise buildings (65).

The survey also gleaned senior preferences for community facilities. Facilities these seniors looked for in a community were "grocery stores (91% of respondents), doctor's offices (88%), pharmacies (82%), beauty / barber shops (71%)" and "dry cleaners (54%), nursing services (50 %), and home care services (44%) (65). These facilities were not desired on-site. Respondents wanted housekeeping and meals delivered to their homes (65). Leisure activities of interest that had land use implications were walking paths, religious services, a library, social / recreation staff, a pool, building-based security, and unit emergency call buttons. On-site parking was desired by an overwhelming majority (the sample was drawn from driving seniors), and less than half were interested in building-based vans and public transit.

Some of the findings were confirmed by the experiences of SAH developers and managers who thought health service access was a useful characteristic for their developments (Granger and Kaye 1991, 69). In addition, since seniors who move to SAH age in place, these developers believe they will eventually need more services. The findings were also supported by a Canadian study that found personal alarms, resident managers, and meal services as the components of SAH of most interest, with the latter most desired by those over 75 (Baker and Prince 1990, 5).

Most survey respondents were healthy, of medium-income, home owners, drivers, and mostly trade or high school educated. Some were college educated and some were employed. Three-

quarters were satisfied with their current housing and over half did not yet move because of "interest in possessions" (64). Those interested in SAH showed no significant differences from those who did not except for their housing tenure; renters were slightly more interested in SAH (Granger and Kaye 1991, 66, 64). The most significant characteristic of those with an interest in SAH was attitudinal; wanting to move to these units while still healthy and independent (66). Persons interested in SAH "were not concerned with losing some independence but instead anticipated freedom from household drudgery" (68, 71). Those not interested in SAH valued it as a future option because of its supportive services (Granger and Kaye 1991, 68). Persons interested in SAH also experienced some problems with home maintenance and poor health. Other demographic characteristics, such as age, living alone, sex, income, location of home (urban, suburban, town, county), education, and number of residents in current household were not significant to an interest in SAH.

Study 2: Preferences of Seniors

The findings discussed above are also generally supported by a similar survey of metropolitan Baltimore seniors (Varady 1990). The current location of these seniors had no influence on housing preferences. Instead, housing type, socio-economic status, health, and stair climbing ability were better indicators of preferences. Financially stressed seniors and those in poor health were most interested in AAs and home sharing (Varady 1990, 87). Owners of large and detached homes were more interested in these two options than were owners of attached units (Varady 1990, 97). More affluent seniors were greatly interested in these options. Better educated seniors, however, were less interested in home sharing, but education had no influence on interest in AA conversion (1990,93). Also, the oldest seniors and those living alone were not very interested in AA conversion. Finally, those who had difficulty climbing stairs were most interested in home sharing.

Study 3: Preferences of Vulnerable Suburban Seniors

While more vulnerable suburban seniors (the sick, poor, isolated) have fewer housing options than do those who are better off, vulnerable seniors, with the exception of poor seniors, more frequently expected to move in two years than did more affluent seniors (Gonyea 1990, 91-93). One-half to two-thirds of these seniors, in various categories of vulnerability, planned to move within their present neighborhood or town. One third of socially isolated seniors, however, anticipated moving out of state (Gonyea 1990, 91). Not surprisingly, these socially isolated seniors were more interested in increasing social contact by moving to residential hotels, adding AAs, house sharing, or moving to a condominium complex. Relatively poorer suburban seniors also preferred residential hotels, a different apartment, and AAs in their homes. All other groups of suburban seniors were uninterested in AAs on their own property, home sharing in someone else's home, and living with children or relatives. Better off seniors who foresaw being forced to move were more interested in condominiums, and the homeowners preferred CCRCs. CCRCs were very interesting to financially better off renters as well, as were converted outbuildings such as barns, carriage houses and garages. New apartments, residential hotels, and AAs on someone else's property were of more interest to moderate income seniors.

APPENDIX 5

The History of Congregate Housing

Congregate Housing units are funded under the Congregate Housing and Services Program (CHSP) created by Title IV of the Housing and Community Services Act of 1978 to serve residents of Section 202 and public housing for the elderly and handicapped (see Redfoot and Sloan 1991). The history of the CHSP is long and has shaped at least two problematic features of the current program. First, the focus had been to mandate and fund meals, group dining areas, kitchens, and kitchen equipment rather than other services and staff (Monk and Kaye 1991, 9). While CH operators are now able to apply for extra funds for some other services and costs, food provision consumes most of the funding allocation. Nonetheless, food preparation and eating are not the activities with which impaired residents tend to want or need help. Instead, housekeeping and medical services are preferred (Monk and Kaye 1991, 12). Second, despite limited federal and state support, many CH facilities do provide services to resident for purchase in packages, on fee-for-service basis, or at a flat rate. For most sites this is at a loss to the facility. In part, these facilities have problems providing services because of rising health and other service costs, preferences for on-site medical care, the limited use of voluntary and community resources, and over-personalized service provision (Monk and Kaye 1991, 13).

Little has changed in the CHSP over the course of a decade and a half. In spite of being the largest of any senior alternative housing program, CHSP continues to be an extremely small program, serving only 62 programs in public housing units and 30 in Section 202 projects in 9 states under short term and extended contracts (Monk and Kaye 1991, 10). Monk and Kaye (1991) contend that the CHSP vastly underserved frail elderly and disabled persons in 1990 (100). In part, this is because of regulations that encourage only 20 percent of the low-income residents with ADL and IADL impairments be served in any one building to prevent the inadvertent creation of nursing home-like institutions within these buildings. These scholars also cite 3 political barriers that have hindered the expansion of and jeopardized the continuation of the CHSP. First, the goal of CHSP has been to prevent the premature placement of disabled seniors into nursing homes. Consequently, the evaluations of the CHSP have been based on only this goal. Other worthwhile goals such as the delay, rather than prevention of institutionalization, improvements in the quality of life of and reduced costs borne by seniors and their families, the avoidance or minimization of short-term acute care hospitalization, and the deinstitutionalization of some nursing home residents have been ignored as goals of CH (Redfoot and Sloan 1991, 103). As a result of this bias, cost evaluations usually compare nursing home cost savings to CHSP costs as the appropriate cost-benefit evaluation of CH. The results have been positive, but less than startling although one study frequently cited as the most thorough, found CHSP to deliver equivalent supports at one-half to one-third the cost of nursing home care (Monk and Kaye 1991, 16).

The second barrier to CHSP expansion is the result of a confused federal policy. The costs, savings, and benefits of the CHSP accrue to different "jurisdictions" and this has stymied efforts to change the program beyond its demonstration parameters (Redfoot and Sloan 1991, 101-103). More specifically, CHSP is viewed as housing by HUD and a service by the Department of Health and Human Services (HHS). Federal and state governments (the funders of nursing

home care through Medicaid-matching budgets) see budget savings from CHSP, while HUD (from the added service costs of CHSP units) and state and local governments (many of which offer subsidies beyond those of the federal demonstration units) only see additional costs. Moreover, efforts to achieve joint federal-state Medicaid savings through joint CHSP expansion, have become entangled in larger state battles over federal mandates in general (Redfoot and Sloan 1991, 103).

Third, the misuse of research outcomes by the Office and Management and Budget (OMB) and HUD in the early 1980s led many policy makers to draw the conclusion that CHSP had failed in its mission and had not offered significant savings (Redfoot and Sloan 1991, 103-107).

APPENDIX 6

A History of Proprietary Senior Rental Housing

Private developers have greatly influenced senior housing. Builders-developers and hotel firms have been the main private organizations to break into the senior housing market. Since the early 1980s, they have shaped the location, type, design, success, and cost of several senior housing options and set the framework for the development of these formats over at least the next decade. Thomas Fairchild, et al. (1991) recount the history of involvement by these two industries in senior housing from which the following information is drawn (157-165).

Initially, trade publications alerted the development and hospitality industries to the growing elderly market in the 1980s. At the same time, commercial real estate over-building and losses and tax reforms stimulated the real estate industry to search for new developments for their properties. As growth outpaced demand in the hotel industry, managers sought new ways to fill their beds. Both of these industries paid little attention to the unique characteristics of seniors and senior housing and approached this market segment in much the same way as they did other segments.

Hotels were the first in the private senior housing business to offer rental units to seniors (Fairchild, et al. 1991, 161). Hotel owners took existing, but underutilized, structures and rented out the larger rooms with hotel housekeeping services included. They added meals, served in the hotel restaurant, transportation, and entertainment to the room rate. The target market was the independent senior. In short order, however, their residents began to require more services and operators struggled with the costs of providing new services in structures that were not designed with their tenants needs in mind.

Later entrees into the field planned slightly more for their target market (Fairchild, et al. 1991, 161-163). They borrowed the continuing care concept from nursing home facilities which divided more dependent seniors according to the level of services they needed by cordoning off subgroups into different types of units and areas on the same site, simplifying care delivery. Services ranged from those associated with independent living (maintenance, transport, some social activities) to skilled nursing services for the more dependent seniors. Facilities were often built on previously unmarketable sites held by developers, such as lots originally laid out for industrial and business parks and large office buildings.

Entrance fees, which further limited access to these facilities to the more affluent senior, were instituted in New Jersey and elsewhere (Winder 1990, 14). In order to take advantage of reduced tax burdens on income from initial fees, these developers charged substantial up-front fee deposits and monthly fees. In 1987, these ranged from $125,000 to $200,000 entrance fee and $1,120 to $2,225 monthly charges (Fairchild, et al. 1991, 162). In this way, tax policy affected the financial structure of the facilities and, consequently, limited these facilities to seniors who commanded the kinds of assets necessary to pay the fees. Other facilities, however, used a rental approach, but were still very expensive. What is more, the high overhead costs and disappointing cash flows made the initial "rent-up" period even more burdensome for owners of these facilities. Nonetheless, developers and hotel owners continued to add these facilities

and both types of operators were the new providers of senior housing, which, until the 1980s, had been almost exclusively offered by non-profits and government.

Finally, throughout the entire period from the late 1970s onward, congregate care facilities were built but filled slowly (Fairchild, et al. 1991, 162-163). The weak demand for these types of facilities has been attributed to the fact that more affluent retirees preferred other forms of housing. Also, over three-quarters of all private market senior "housing built in the early 1980s was designed for the affluent, who made up only 20 percent of the elderly population" (Fairchild, et al. 1991, 163). In short, supply exceeded demand in this niche market.

APPENDIX 7

Subsidized Senior Rental Housing in New Jersey: A Summary of Research Findings in the 1991 Survey[7]

Location Characteristics of Subsidized Rental Units

Bergen and Ocean Counties led the state in 1991 in the share of the state senior population. Bergen County had over 12 percent and Ocean County had over 9 percent of the state's seniors. But the two counties were under-represented in senior subsidized units with 6.7 and 2.3 percent, respectively, of the state total. Essex and Hudson Counties had more than their share of senior subsidized units, with 24.6 and 12 percent of all units, respectively, compared to 9.5 and 6.8 percent of the senior population. These more urbanized counties had built up their supply of senior subsidized buildings since the 1960s, but more recent construction has been in suburban and rural areas. Nonetheless, the striking slowdown in subsidized senior housing has made it hard for other counties to enlarge their supplies.

Building Characteristics

In addition to the rapid slowdown in construction, new buildings that have been built are much smaller than those of the recent decades. Very large structures were built in the late 1960s and early 1970s. The 1980s witnessed a return to buildings with 100 or fewer units. Also, over 71 percent of all units were one-bedroom configurations in these smaller projects.

Resident Characteristics

The U.S. Department of Housing and Urban Development requires residents of subsidized senior housing to be 62 year and over, or disabled and at least 18 years old. Senior residents comprise 92 percent of all residents in these units in New Jersey. The average entrance age was about 69 years, with considerable variation across counties. In addition, 50 percent of public housing, and 69 percent of "other funded" projects had some kind of restrictive preferences, while few Farmers Home Administration-funded projects had such preferences. Residency restrictions required project residents to be or have, in order of frequency: (1) town residents or employees; (2) former residents or employees; (3) other specified characteristics; and (4) county residents. These restrictions were most prevalent in Sussex, Morris, Cumberland, and Union Counties. Finally, newer and/or larger buildings have tended to entail fewer preference requirements.

Staff and Services

The pre-1969 and post 1988 buildings have smaller staffs, as do smaller buildings and buildings with higher concentrations of residents under age 80. About 25 percent of all buildings have no staff and 38 percent have 1 to 3 staff persons. A typical staff consists of a manager and two maintenance staff. Services are identified as more expensive essential services (one on-site hot

[7] These findings are drawn directly from a report written by James Hughes and K. Tyler Miller, 1992.

meal in a central dining area, and housekeeping or personal assistance) and the less expensive supplemental services (a wide range that includes information and referral, Meals on Wheels, health and social services, recreation, and transportation). As building size increases, the tendency to provide services decreases. Services (essential and supplemental) are positively linked to the numbers of support service staff.

Waiting Lists

Most subsidized senior rental units in the state had very low vacancy rates by county and by building type. The exceptions were the less desirable older buildings. With such low vacancy rates, most buildings have long waiting lists. These lists serve as a rough estimate of demand, although people do register on multiple lists, and therefore, demand is probably lower than the lists directly indicate. In addition, waiting lists differ by sponsor type due to federal preference requirements for different sponsors. Subsidized rental senior housing is sponsored by government, non-profits, and limited-divided companies. Preferences favor those who face displacement due to government actions and recognized disasters or are occupants of recognized substandard housing, are homeless, or are families paying more than 50 percent of gross monthly income on rent (Hughes and Miller 1993, 32). About 58 percent of waiting lists for government-sponsored units were federal preference households. Also, counties varied substantially in the portion of households on their waiting lists with one or more preferences, ranging from 2.3 percent in Hunterdon to 50.0 percent in Union.

APPENDIX 8

Sample New Jersey Senior Housing and Service Programs

The program descriptions and funding allocations presented below are provided to give a very general idea of the types of programs offered and relative funding priorities. Readers who want more recent and expansive information should contact the appropriate agencies.

New Jersey Department of Community Affairs - 1991 Comprehensive Affordable Housing Strategy Funding Proposals for Fiscal Year 1992 and as listed in the 1993 Annual Plan.
1. The Congregate Housing Services Program - Maintains frail seniors in subsidized CH facilities with services. Funding proposal: $1.85 million.
2. Continuing Care Retirement Communities Program - Provides below market-rate financing for senior rental housing with services. Funding proposal: included in the Multi-Family Rental Program.
3. The Services for Independent Living Program - Grant support for research, development, and administration of services for low-income frail seniors in HMFA-financed senior housing projects. Funding proposal: $0.43 million.
4. Life Safety Improvement Rental Assistance Fund - Assists B&Cs and RHCFs to meet safety requirements with subsidized loans Funding proposal: $3.2 million.
5. Boarding House Life Safety Improvement Loan Program - Assists B&Cs to meet fire safety requirements through subsidized loans. Funding proposal: $0.15 million.
6. Senior Safe Housing and Transportation Program - Assists seniors in private housing, subsidized housing, and multi-unit dwellings, including SLRs, to increase security, fire safety, health and safety, repairs, modifications, and exterior chores. Funding: $2.88 million.
7. Weatherization Assistance Program - Assists low-income seniors and others to conserve energy and reduce costs. Funding: $5.3 million.
8. Aging Network Service Groups provide counseling for HUD reverse mortgage programs. This will be available in all 21 counties (NJDCA 1993).
9. Section 202 Housing Units - Senior subsidized housing at or below 50 percent of median county income.
10. HUD HOPE for Elderly Independence Demonstration Program. A 5-year demonstration program to assist 70 frail seniors in Atlantic and Union Counties by combining Section 8 Rental Assistance for subsidized housing with supportive services.
11. A NJDoA and NJDHS joint program to develop packaged services, models and regulations for ALFs for low-income frail seniors in subsidized housing.
12. A NJDoA seed funding and training program for nonprofit and housing agency reverse mortgage counseling programs.

New Jersey Department of Treasury - 1994
1. Senior Citizens Property Tax Deduction - Provides a $250 tax deduction for low-income senior home owners.
2. Veteran's Property Tax Deduction - A $50 tax deduction for qualified veterans.
3. Realty Transfer Fee Partial Exemption - Available to senior home sellers.

New Jersey Department of Health - 1994

1. Lifeline Assistance Program - Provides $225 annual cash benefits to low-income seniors for utility expenses.

Bank Programs - 1994
1. There are several privately funded reverse mortgage programs in some parts of the state.
2. A federally insured reverse mortgage program available to senior owners of single-family homes with specific equity balances is offered throughout the state.

New Jersey State Laws
1. Rent Grace - 5 days from first of the month for seniors.
2. Senior Citizens and Disabled Protected Tenancy Act - Prohibits eviction of tenants for 40 years after condominium conversion.

Municipal Programs
1. ECHO Units - NJDCA demonstration grants to communities that have developed ECHO ordinances.
2. AA Units - Bergen County Housing Authority uses U.S. Administration on Aging and NJDCA grants to help home owners build AA units as low-income rental units. The Authority also assists municipalities to fashion appropriate ordinances.
3. Cluster Congregate Care - Demonstration grants by NJDoA and NJDoHD to a non-profit organization to develop model services for market-rate NORCs.

Sources: New Jersey Departments of Community Affairs, Treasury, and Health. 1992, 1993, 1994.

APPENDIX 9

The Land Use Impacts of New Jersey's Aging Population: A Three Part Research Agenda

A RESEARCH PROPOSAL for PARTS II and III

Part II: New Jersey's Future Senior Population - Housing and Service Needs. This part could evaluate housing and service demand and supply appertaining to the state's geography. Part II could have at least three sections. The first section might include detailed population, household, income and asset, disability, and housing demand and supply estimates and projections by age, sex and race, and tenure type. These could be made using a variety of alternative assumptions about, for example: headship rates among senior subgroups; land prices; incomes, social security and pension benefits, other entitlements, and other investment assets; equity conversion usage; property tax burdens, and disability rates. Determinations of future needs for housing, related personal, health and social services, and transportation, could be based upon the projections. In addition, relationships between demographic shifts among younger cohorts and seniors could be fleshed out in more detail. Three examples might be: (1) the impacts of limited demand for starter housing on senior housing equity and center and suburban development; (2) a more thorough analysis of social security contributions based on labor force cohorts, social security payment demand by seniors, and public policy shifts; and, (3) the shrinking demand for baby boomers large, newly built, trade-up units and overhousing in the suburbs and exurbs. The second section of Part II could survey, to the extent possible, current housing for seniors by tenure type, cost, subsidy form, location, and levels of personal and other assistance. This could be done by collecting information from other agencies and independent researchers, supported by follow-up data collection. Again, geographic analysis should be included. The final portion should attempt to ascertain the nexus between supply and demand based on trend information and identify geographically-linked footprints, infrastructure needs, problem areas, planning and policy issues, and make recommendations.

Part III: New Jersey's Growing Senior Population: Implications for Land Use and The New Jersey State Development and Redevelopment Plan. This last part would tie Parts I and II together using extensive analysis of the available data and formulate detailed policy and planning recommendations for: (1) refinements in The State Development and Redevelopment Plan and the planning process; (2) interagency collaborative data collection, research, policy, planning and implementation efforts; (3) intergovernmental (state-municipal, state-county, state-regional, interstate) data collection, research, policy, planning and implementation efforts. This portion of the study is anticipated to have direct implications for the Housing, Urban Revitalization, Economic Development, Public Services, and Intergovernmental Planning Goals and Strategies in the SDRP. In addition, indirect implications are anticipated for every portion of the SDRP. Finally, the findings should lead to policies with considerable potential for greater efficiency in inter-agency and inter-governmental planning and cooperation.

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