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Differing Prospects For Women and Men: Young Old-Age, Old Old-Age, and Elder Care

by

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ABSTRACT

Although elderly men and women share many of the same problems as they age, their lives are likely to follow different courses. Women are more likely than men to live into old old-age and are more likely to spend part of their young old-age caring for husbands or parents. By providing this unpaid care women might enter retirement earlier, rather than prolonging their working lives. Because they live longer, but are less likely than men to live with someone who will care for them, women are also more likely than men to require paid care either at home or in a nursing home. Proposals to reduce government spending on Social Security, Medicare, and Medicaid will thus have different implications for women and men. This paper evaluates changes in these programs, and describes alternative and innovative ways of providing and paying for eldercare in other countries as well as in the United States.

JEL classifications: H55, J14, J16, J26, J32

Keywords: elder care, long-term care, gender differences, retirement policies, economics of aging

This paper addresses the question of government spending on the elderly from a woman's perspective. The point of view I bring is that of an **old woman—**a semi-retired, feminist economist, who is a participant observer of the process of growing old. I live in a Continuing Care Retirement Community and so am well situated to observe the aging of my neighbors and friends, as well as myself. In this paper, I will comment on the some of the policies being advocated or adopted that may affect women and men in different ways.

Although Social Security has received the most attention, expenditures for Medicare and Medicaid are projected to increase even more rapidly than Social Security spending. Some of the policies advocated for these programs may interact in unexpected ways. Regarding Social Security reform, increasing the age of eligibility to promote longer working lives has often been advocated. At the same time, proposals are made to constrain Medicaid spending by shifting more of the care of the disabled elderly to unpaid caregivers, primarily women, but also some men, many at the ages when they are also being expected to do more paid work.

The elderly are conventionally defined as the population age 65 and over, but this is a very broad age range, and the capabilities of different individuals are likely to vary widely. When we consider work and retirement, we tend to be thinking about young old-age, when most people are physically active and able to care for themselves. There is considerably less research, at least by economists, on old old-age when disabilities increase, most of the elderly begin to need some assistance, and many require extensive help with the most basic activities of daily living.

Although elderly men and women encounter many of the same problems as they age, their lives are likely to follow different patterns. Men are less likely than women to live into extreme old age; women are, therefore, an increasing majority of the elderly at older ages (see Table 1). Men are also likely to have married women younger than themselves. As a result, while the majority of both men and women ages 65-74 are married, by ages 85 and over approximately 59 percent of men are married compared with only 14 percent of women**.** Then, if they become ill or disabled, men are much more likely than women to have spouses who can be caregivers, whereas women are more likely to depend on adult children. These patterns will, however, certainly change with

health improvements and different marital patterns as the baby boom generation ages, a topic I will return to later.

YOUNG OLD-AGE: PAID WORK, UNPAID WORK, OR LEISURE?

Paid Work: Working Longer

Retirement often occurs even before age 65, most commonly at age 62 when eligibility for Social Security begins. As life expectancy increases, encouraging people to work longer seems reasonable. One proposal is to gradually increase the age of first eligibility for Social Security benefits beyond the current age of 62 years. More commonly proposed is to continue raising the age of qualification for full Social Security benefits beyond the currently scheduled changes from 65 to 67 years. Such proposals would, in effect, be benefit cuts for anyone who cannot work past age 62. Either proposal would cause the greatest hardship for some of the most vulnerable elderly, especially minorities and other low-income individuals who cannot continue to work because of poor health, inability to find work, or responsibilities for family members.

Proposals for later retirement would have the greatest impact on workers in physically demanding jobs, more frequently held by men than women. However, some occupations that are not especially demanding for younger workers become more difficult at older ages. These include many service occupations and some retail sales jobs that require standing or walking for long periods. Large proportions of these jobs are held by women. According to data from the Health and Retirement Survey (HRS), slightly more than half of workers in service occupations and about one quarter of those in sales reported that their jobs involved much physical effort all or most of the time (U.S. General Accountability Office 2005b). Increasing the early or normal retirement age should be accompanied by changes that make disability benefits more readily available for people who cannot continue to work because of the physical demands of their jobs.

Working longer will only be possible to the extent that employers are willing to hire older workers. At present, companies that are downsizing often encourage their older workers to retire even before age 62. Studies show that although unemployment is generally low at older ages, older workers who do lose their jobs are unemployed for

longer periods and may eventually stop trying to find work (Flippen and Tienda 2000). Many workers believe that if they wanted to work to older ages, either their own lack of up-to-date skills or employers' discrimination against older workers would prevent them from doing so (U.S. General Accountability Office 2005b).

If labor shortages develop as the baby boom generation retires, perhaps more employers will be interested in providing options such as phased retirement, allowing for part-time or part-year employment which few employers now offer (U.S. General Accountability Office 2005b). A slight trend toward more employment at older ages appears to have already begun. For example, labor force participation rates at ages 65-69 were 33.6 percent for men and 23.7 percent for women in 2005, up from 24.4 percent and 13.5 percent in 1985. These trends could reflect better job opportunities or could be due to many people feeling the need for more income as the cost of medical care increased more rapidly than inflation.

Unpaid Work: Caregiving Responsibilities

Another problem of a longer working life that is seldom recognized is that many women and some men in their 50s and 60s may find it difficult to continue working for pay because they are needed as caregivers for their spouses, parents, or other relatives. Research suggests that informal care by spouses or adult children delays the use of nursing home care and reduces the use of formal paid home care (Van Houtven and Norton 2004; Charles and Sevak 2005). Consequently, encouraging care by family members is frequently mentioned as an option for reducing pressures on public programs (Wolf 1999). Additionally, reductions in Medicaid availability at both state and federal levels may well be forcing families to assume this responsibility.

Relatively small amounts of assistance can usually be combined with paid employment, and when family relationships are good, may be very satisfying to the caregiver. Sometimes, elderly parents who are in relatively good health can reciprocate by occasionally or even regularly taking care of grandchildren. On the other hand, caring for those who require considerable help with the so-called instrumental activities of daily

living (IADL) may be quite time-consuming.[1] Even more difficult to combine with paid work is the more intensive care required for those who need assistance with the such activities of daily living (ADL) as dressing, bathing, eating, moving around indoors, and using the toilet.

This country appears to be following the path taken by some European countries: encouraging more paid work and increased unpaid elder care (Stark 2005; OECD 2005). Women are more likely than men to be involved in these conflicting demands. In the United States, spouses and daughters are the most common caregivers; wives are approximately 60 percent of spouse caregivers, although husbands play a significant role as well, in part because they are so much more likely than women to be married. Among adult children, daughters (or daughters-in law) are much more likely to provide extensive care than are sons, sons-in-law, or other relatives or friends (Johnson and Wiener 2006; Wolf 2004).[2]

Nearly all spouse caregivers are over age 55, approximately one third of them in the 55-69 age range, the ages when more paid employment is being advocated (Johnson and Wiener 2006). Nearly one-quarter of daughter caregivers are age 60 and over, approximately one third are in their fifties, and another third are in their forties; many of them are employed (Johnson and Wiener 2006). Thus, the conflict between paid work and care-giving may arise for women and some men, not only when they are raising children but also at older ages when they must provide care for spouses or elderly parents (Gross 2006). Some of the younger caregivers may be caring for both parents and children.

When increased family care is recommended as a way to reduce dependence on expensive nursing home care, the most intensive kind of care is implied, and co-residency is often required. Wolf (1999) argues that care by family members, specifically adult children, can be more efficient than paid care. Co-resident care can indeed offer economies of scale. In some cases, a parent's retirement income can also make a substantial contribution to the family's welfare.

[1] IADLs include being able to manage money and medications, use the telephone, shop, cook, and do light housework.

[2] Estimates of the characteristics of caregivers of the elderly vary across years, source of the data, and the kind and amount of care being provided. The estimates shown are for those helping with ADLs.

On the other hand, the potential stress for both the recipient and the caregiver should not be ignored. Bringing a parent into the home of an adult child can require difficult adjustments for both parent and child. A Canadian study finds that providing care for a parent living in the household is far more stressful than the same amount of child care (MacDonald, Phipps, and Lethbridge 2005). Intensive care, especially for an elderly person with dementia, can put enormous strains on the caregiver. Those who have to give up their jobs or reduce their hours of paid work may also be jeopardizing their own retirement incomes.

The value of caregiving to society may well exceed its net value to the caregiver, who pays much of the personal and financial cost. Therefore, public support to encourage caregiving by family members is warranted (Wolf 1999; Folbre 2004). For example, the use of adult daycare can allow the caregiver some respite to do necessary tasks such as shopping. In some cases, such an arrangement can even allow caregivers to continue with their regular jobs. However, adult daycare facilities are not available in many communities and are rather expensive, even though they cost considerably less than nursing home care. Some states permit Medicaid to pay for adult daycare.

Countries such as Australia, Canada, Sweden, and the United Kingdom have tried to ameliorate the elder care problem by providing allowances to support caregivers (OECD 2005). Some of these countries have also provided social insurance benefits for caregivers. Proposals for caregiver tax credits or added years of Social Security coverage have been made in the U.S. Congress, but have not been enacted (Wolf 2004).

Leisure?

If we make adequate provisions for those who are not able to work because of disability, care responsibilities, or inability to find a suitable job, it should be possible to encourage longer working lives for those in young old-age who are able and willing to work for pay. The question arises, however, whether we should also allow a place for leisure at some point before old old-age? Policies to encourage more paid work, even past age 70, sometimes take on a rather puritanical tone that is reminiscent of the old hymn, “Work for the night is coming when man’s work is done.” This hymn enjoins us in successive

verses to work through the morning hours, through the sunny noon, and while the night is darkening; the work ethic indeed.[3]

Perhaps we are a bit influenced by the media view of the wealthy young-old people who go on cruises and other exotic vacations and live in retirement communities with golf courses. This picture may apply to some members of the upper-middle class and many of the upper class, but for most other people, the reality is very different. Many are caring for aging spouses or even still working, at least at part-time paid jobs. For most, leisure is more likely to consist of simpler pleasures like gardening, visiting with neighbors, napping, and playing with grandchildren. Even this last activity, for women especially, sometimes becomes part or even full-time caregiving to help their daughters or daughters-in-law hold paid jobs. In African-American and other low-income communities, grandmothers are sometimes raising their grandchildren alone (Joslin and Brouard 1995).

OLD OLD-AGE AND THE NEED FOR CARE

At the same time that life expectancy has been increasing, disability among the elderly has decreased (Cutler 2001). Many women and men who live into old old-age remain in relatively good health, but as they reach their late 70s and into their 80s, more of them develop problems that may interfere with their ability to live independently (see Table 2).[4] Low vision becomes an increasing problem, and many old people lose some of their independence because they can no longer drive a car.

Although women are more likely to live to older ages, they are also more likely than men to have mobility problems at each age. Women are more likely than men to be disabled because of arthritis, osteoporosis, or following a fall. These conditions are usually not fatal, but can lead to long periods of disability. Men, on the other hand, are more often disabled because of heart disease or strokes and do not live as long with these conditions (Guralnick et al. 1997). Dementia, probably the most disabling and most feared disability, rises rapidly with age to affect approximately 17 percent of women and

[3]For the complete hymn see www.cgmusic.com/cghymnalothers/workforthenight.htm.
[4] Some part of these age differences could, of course, be due to cohort effects.

21 percent of men by age 80 and 30 percent of both men and women ages 85 or over (Federal Interagency Forum 2004).[5]

Among married couples, caring for an ailing spouse is common. Approximately 45 percent of spouse caregivers are in their seventies and some are in their eighties, when their own health may be a constraining factor (Johnson and Weiner 2006). Although most elder care is provided by spouses or other unpaid caregivers in the community, many of those needing care, women especially, live alone and have no relative who can assist them. After age 75, the majority of women are not married (Table 1) and nearly half live alone (Shaw and Lee 2005).

Among the elderly residing in the community,[6] about 20 percent of those who need assistance with either ADLs or IADLs rely on paid caregivers (Wolf 2004). More women than men rely on paid care, even though they have less income and fewer assets than men. The majority of paid caregivers are also women, predominately African-Americans or Hispanics (Wiener and Tilly 2002). The work is usually low-paid and seldom provides benefits. Turnover is high, leading to a high level of insecurity for those relying on this kind of care.

Formal long-term care is most commonly provided in nursing homes, although some small room and board facilities also offer complete care. Residence in nursing homes increases rapidly with age. In 1999, approximately 3 percent of men and 5 percent of women lived in nursing homes at ages 75-84, and the percentages increased to 11 percent of men and 20 percent of women age 85 and over (see Table 2). Approximately three-quarters of nursing home residents are women. About 72 percent of nursing homes are operated for profit, and the quality of care is often poor (Eaton 2005).

The average cost of a year in a nursing home is $70,000 (MetLife Mature Market Institute 2004). While the median net worth of elderly married couples was $170,000 in 2000, median net worth of female householders age 65 and over was $75,275, barely enough to cover one year in a nursing home (U.S. Census 2000). Hence, many nursing

[5] These figures are underestimates because they include only the non-institutional population.
[6] Most community-based care is provided in private homes, but as discussed later, assisted living and other arrangements are becoming increasingly popular. Residents of assisted living facilities, in particular, are considered part of the non-institutional population, but may not be adequately represented in surveys (Schoeni et al. 2005).The Federal Interagency Forum on Aging-Related Statistics recommends more attention to these newer kinds of living arrangements for the elderly to be sure their residents are accurately counted (Federal Interagency Forum 2004).

home residents exhaust their savings within a year or two of entry, and then become dependent on Medicaid. Nursing homes may be reluctant to take people who are on Medicaid, making it more difficult for lower-income people to find accommodations. (Harrington Meyer 2001).

Paying for Long-Term Care

For elderly women especially, paying for the care they need is often a major problem, whether they remain in their homes or go into nursing homes. Over half of long-term care for the elderly is paid for by federal and state governments—Medicaid paid for 35 percent and Medicare 25 percent in 2004. Only 4 percent was paid for by insurance; the rest (36 percent) was paid for out-of-pocket by the recipients, their families, or other sources such as charitable funds (Johnson and Uccello 2005; Congressional Budget Office 2004).[7]

Nursing home care, however, involves much higher Medicaid expenditures than home-based care. In 2004, Medicaid covered approximately 40 percent of nursing home expenses compared with 25 percent of home-based care expenses. Medicaid is not an entitlement and is administered by the states, which can determine eligibility within limits set by federal law. Medicaid has been described as insurance in which the deductible is your life savings and the co-payment is your annual income (Quoted in Clark et al. 2004). More stringent rules for Medicaid eligibility are a favorite recommendation for curbing government expenditures on the elderly (Congressional Budget Office 2004). Women are not only the primary recipients of Medicaid, but also the primary caregivers who will be under pressure to provide more unpaid care.

Medicare plays a larger role in home-based, long-term care because it pays for skilled nursing care that is provided at home on a daily basis. It also pays for short-term

[7] These figures do not take into account the value of unpaid care. According to the Congressional Budget Office (2004), the value of unpaid care could account for as much as 36 percent of long-care expenses, bringing the total amount from private sources both paid and unpaid to over 60 percent of total costs. Wolf (2004) explains some of the different ways of valuing unpaid care, and some of the sources of both over and under-estimation.

care in nursing homes that provide skilled nursing care after hospitalization, but does not pay for custodial care on a long-term basis (Johnson and Uccello 2005).

Private spending by the care recipient or her/his family also represents a major source of payment for long-term care. Out-of-pocket medical expenditures of all kinds are usually largest in the last years of life, reaching approximately one quarter of annual income for the median couple and over one-half of annual income for 20 percent of elderly couples (McGarry and Schoeni 2005). If assets are drawn down to pay for medical expenses, the surviving spouse, most commonly the wife, will be less likely to be able to pay for her own expenses in her last years.

One possible remedy is long-term care insurance, which is relatively new but is likely to become a more important way of paying for long-term care in the future. Premiums at age 65 average approximately $2,000 per year for a guarantee of an inflation-adjusted payment of a stated amount for 3-6 years (Congressional Budget Office 2004). Purchase of life-time coverage is even more expensive. While premiums are considerably lower if purchased before age 65, they increase rapidly with age. However, Consumer Reports does not recommend earlier purchase because of the risk of having to drop the insurance if income should decrease or premiums should be increased enough to make them unaffordable (Consumer Reports 2003).[8] Furthermore, an estimated 15 percent of those applying for policies are turned down for health reasons, and some purchasers have also found it difficult to get companies to pay when long-term care is needed. Therefore, long-term care insurance can by no means solve everyone's problems.

ELDER CARE IN THE FUTURE

In 20 years, members of the large baby boom generation (born in 1946-1964) will all be in what is now the usual retirement ages, and the oldest will have reached age 80. The situation I will discuss here is based on current trends, but disasters such as abrupt

[8] While premiums are supposed to be fixed at the age of purchase, insurance companies have sometimes been successful in getting grants from state regulators for large increases in premiums if they find their premiums are not covering costs (Johnson and Uccello 2005). Over a long period of years, there is also greater risk of company bankruptcy as well.

climate change, wars over energy sources, or epidemics could completely change this picture.

Although the baby boom generation will probably be healthier than today's elderly, total medical expenditures are not likely to decline because of their large numbers (Wiener and Tilly 2002.). The decrease in disabilities that has occurred in recent years has been greatest for the well-educated and relatively wealthy (Schoeni et al. 2005). Therefore, increasing income inequality, as well as increasing disability at younger ages due to such factors as increasing obesity (Congressional Budget Office 2004), portends smaller decreases in old-age disability than in the past. In any event, both Medicare and Medicaid are likely to be under great pressure because of the size of the baby boom generation (U.S. General Accountability Office 2005a). A likely outcome is that eligibility or payments are likely to be further reduced, putting more of the burden on families for unpaid care.

At the same time, family care is likely to be less available than it has been. It is uncertain whether as much spouse care will be available for either women or men. On the one hand, fewer of those in their 40s and 50s are married than was the case for the current elderly population. On the other hand, increasing life expectancy may reduce the likelihood of becoming widowed. In any case, a larger percentage of the younger generation is predicted to be divorced or never married (Butrica, Iams, and Smith 2003).

Another important difference between today's elderly and baby boomers is that the latter have had far fewer children than their parents. Nearly 60 percent of women who are now in their 70s had had three or more children by ages 40-44, compared with only about 30 percent of women born in 1956-60. Similarly, only 10 percent of the older women had no children by their early forties, compared with 19 percent of the younger group (U.S. Census 2005). Therefore, care by children, mainly daughters, which is such an important source of care for elderly women today, will also become much less common.

For all these reasons, additional sources of elder care may be necessary in the future. Sons and sons-in-law may need to provide more care than at present. Siblings, friends, and perhaps nieces and nephews may also become more important sources of care. In any event, it is probable that an increased reliance on paid care will be necessary.

Until now, shortages of nurses and other care workers have often been recruited from the developing world (Callahan 2001). Immigration, especially large flows of migrants from Latin America, has now become the subject of much controversy. Rather than depending so heavily on poorly paid immigrants, a better policy would surely be to provide higher wages and better working conditions for care workers in order to attract and retain high-quality workers, whether native-born or immigrants.

Higher rates of saving could potentially reduce the need for higher government spending on elder care when the large baby boom generation retires. Members of this generation are expected to have higher incomes than the current elderly generation and would clearly benefit from saving more. Nevertheless, the increasingly unequal distribution of income means that many of them, including families with below-average incomes and the majority of unmarried women, will not be able to save enough to pay for long-term care if they need it (Van Derhie and Copeland 2003).

In addition, fewer workers in the future will have income from defined benefit pension plans, and the defined contribution plans that are replacing them are usually taken as lump-sum benefits rather than annuities (Shaw and Hill 2002). This exposes retirement income to investment risk, especially since many people do not have the skills required for successful long-term management of assets (Copeland 2005). Hence, the risk of out-living assets may very well increase for this generation.

Long-term care insurance will probably become a more important part of paying for long-term care. Federal employees, for example, already have the option of including long-term care insurance as a fringe benefit. Long-term care premiums are, at present, deductible as medical expenses once total medical expenses exceed the required percentage of income, but this is most useful for the wealthy in higher tax brackets. Use of home equity to buy long-term care insurance through reverse mortgages has been suggested, but is not yet widely practiced. Reverse mortgages could also be used to pay for long-term care directly (Rich and Porter 2006), but this again is most useful for those who own expensive homes.

In the past ten years, Germany, Japan, Austria, and Luxembourg have instituted state-provided long-term care insurance systems (OECD 2005). These systems might provide useful models and should be studied carefully as they mature. Adding long-term

care insurance to Medicare might be a good option for the United States as well. This might be done by increasing the payroll tax, but could be accomplished in a less regressive way by reinstituting the estate tax at higher levels and dedicating the proceeds to universal long-term care insurance.

An important strategy to reduce long-term care expenditures is to delay the need for full-time care by helping the individual to remain active longer. Assistive devices, such as walkers and motorized scooters, allow old people to move about more easily and have been found to reduce the number of hours of personal assistance needed (Hoenig, Taylor, and Sloan 2003). Also, medical advances such as cataract surgery, hip and knee replacement, and various treatments for heart conditions have allowed people to live longer active lives. Here, as in other aspects of government spending, increased (decreased) spending of one type (Medicare) may lead to reduced (increased) need for other spending (Medicaid).

Retirement communities with services are a growing source of support for the elderly with mild disabilities or those who anticipate that they may need services in the future. Because providing care at home or in communities with services is less expensive than nursing home care, some states are attempting to shift funds for seniors in this direction. About 7 percent of the population age 85 and over at present live in such senior communities (Federal Interagency Forum 2004). Some communities offer senior low rent housing and services such as transportation to stores. Congregate housing facilities usually offer individual apartments with common dining facilities and other common areas. Assisted living facilities usually provide all meals and services such as laundry, housecleaning, and assistance with medications for those who need such help but are still able to do many things for themselves. This kind of assisted living usually costs considerably less than nursing home care.

Continuing care retirement communities offer a range of services including independent living, assisted living, and full nursing home care.[9] Communities of this kind provide settings in which it is easy for elderly people to help each other in various ways that can delay the time when more expensive formal care is needed and thus reduce

[9] The Appendix describes the continuing care community in which I live in some detail.

government expenditures on Medicaid. It is my hope that the baby boom generation will be able to think of still other ways to help themselves and each other in old age.

Table 1. Percent Married, Probability of Surviving to Next Age, and Percent Female by Age

	Percent Married[a]		Probability of Surviving to the Next Age[b]		Percent Female[c]
Ages	Men	Women	Men	Women	
65-74	77.6	56.1	0.747	0.828	54.2
75-84	72.8	36.6	0.485	0.606	59.2
85 and over	59.4	13.9	N/A	N/A	66.3

[a] Source: U.S. Census Bureau, Current Population Survey, as reported in Federal Interagency Forum on Aging-Related Statistics, 2004, Table 3.
[b] Calculated from Life Tables for Males and Life Tables for Females, National Vital Statistics Reports, 2002.
[c] Calculated from Current Population Survey, 2004; excludes population in nursing homes.

Table 2. Disabilities and Nursing Home Residence by Age and Gender			
Ages	Trouble Seeing[a]	Impaired Mobility[b]	Nursing Home Residence[c]
(Percentages)			
MEN			
65-74	13.3	13.0	1.0
75-84	16.2	21.3	3.1
85 and over	29.2	35.1	11.7
WOMEN			
65-74	15.5	26.0	1.1
75-84	19.1	32.9	5.1
85 and over	34.7	59.5	21.1

[a] Source: Federal Interagency Forum on Aging Related Statistics. Older Americans 2004: Key Indicators of Well-Being.
Table 16a, Non-institutionalized civilian populations, 2002.

[b] Table 19c, Medicare enrollees, 2002.

[c] Table 35a, Percent of age group, 1999

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APPENDIX

An Example of a Continuing Care Retirement Community (CCRC)

The CCRC I live in has features that allow the elderly, especially those living alone, to delay the time when they will need the full care of a nursing home. We are a not-for-profit community with over 1,000 residents, the majority living in independent living apartments. One meal a day is covered by a monthly fee, but breakfast and lunch are available if desired. A small grocery store, beauty salons, doctor's offices, and a pharmacy are on the premises. About three-quarters of the residents are women, the majority of whom are widowed, divorced, or never married. According to a recent survey, only 2 percent are in their 60s, about 35 percent are in their 70s, over half are in their 80s, and 10 percent are 90 or over. (These figures may under-represent those in their late 80s and beyond as they are probably less likely to respond to written surveys.)

Although the population is definitely middle or upper middle class, it is not limited to such a high-income population as some have supposed. Our friends are retired teachers, librarians, and housewives. Most of the men were civil servants, but one we particularly enjoy talking to was a train conductor. We continually meet people who have lived here for more than 10 years, some more than 20 years. Those who need daily help usually move into assisted living, but a few hire their own helpers. A nursing home provides after-hospital care and physical therapy for those recovering from hip or knee surgery. Full long-term care is also available, including a special wing for care of Alzheimer patients. There is also an adult day-care unit used as respite care by spouses of residents, as well as by people in the surrounding community with early-stage Alzheimer's.

Residents offer each other help of various kinds. Those who still drive may take others shopping or to doctor's appointments. Many who are becoming forgetful have friends to remind them to come to meals. People in the nursing home unit after surgery usually have well-wishers who send cards or flowers and visit them when they are well enough. This kind of friendly environment is particularly important for those who have no family or friends living nearby.

Although the nursing home unit does depend partly on Medicare and Medicaid funding, there is also a benevolent fund to help those whose income and assets fail to cover all their costs. Many residents contribute to this fund, as do people in the surrounding community. No one has ever been asked to leave because of insufficient funds. In an area with lower housing costs than the one in which we are located, this kind of non-profit community, organized by religious or other voluntary groups, could offer a retirement alternative to a broader range of older people living alone.