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Demographics: The Market Driver



**POPULATION GROWTH AND THE MARKET
CHANGING NEEDS OF SENIORS
DEMOGRAPHICS AND PRODUCT LINE**

1

Later in this course, we will discuss in detail the importance of addressing seniors’ housing and care as a *service*, not a product. One key difference between the two is that the numbers (such as population of seniors in the target area) are not as important as the targeted customers and their essential characteristics. What kind of living environment do they want? What kinds of recreational and social activities? What sort of relationship with the staff?

Of course, demographics do help developers assess markets, determine how to compete with existing and planned facilities, etc. However, the success of the project depends on an understanding of three variables:

1. Who is the customer for the kind of facility planned?
2. What does this customer need or want?
3. What kind of service will attract and retain these customers?

These variables are more than just numbers; they are what lies behind the numbers. An understanding of these characteristics will help the developer determine the type of service most likely to succeed.

NOTES

The Johns Hopkins Bloomberg School of Public Health
“Managing Long-Term Care Services for Aging Populations”

*Why Are Demographics
Important?*



- Determines Need (Demand)
- Determines Support (Supply)
- Shapes Public Policy
- Structures Social/Economic Institutions
- Fosters Almost Revolutionary Change

2

Demographics determines both the supply and demand for senior living facilities:

- Demographics determine the level of need (Demand)—albeit not mathematically.
- Demographics determine the level of support (Supply)—albeit not mathematically.

In the context of the “Graying of America,” these changes can be truly remarkable and of considerable significance for those providing products and services to the elderly.

Demography also shapes public policy, as reflected in the debates regarding Social Security and Medicare—and social/economic institutions (work, family, economy, health care systems).

Meyers and Eggers describe the impact of the demography of aging as a true “gerontological revolution.”

NOTES:

The Reality of Numbers



- “Causes of Gentrification”
- Longevity Begets Longevity
- Aging Society = Developed Society
- “Aging Societies” and Social/Economic Attributes
- Life Span Unchanged

3

The key factors accounting for demographic trends (in terms of gross numbers) are birth rates, mortality and immigration. “Aging societies” experience low fertility and low mortality.

Longevity begets longevity: the greater the percentage of a population that reaches a certain age (say, 65), the greater the population that will achieve a higher age (for example, 85). Life *expectancy* in America has increased 50% since 1900.

Still, the maximum life *span* of 115 years remains constant, suggesting an upper limit to human longevity regardless of medical advances or any other factors.

The more-developed countries have a higher percentage of elderly, perhaps because of such factors as better health care, nutrition, and (as discussed later) education.

One can see a correlation between the age of a society and its stage of development. And a society’s development can even be reversed, and will be reflected in its demographics. (Russia is a prime example.)

NOTES:

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“Managing Long-Term Care Services for Aging Populations”

“I Want to Live Forever”

- Increase in Life Expectancy
- 1900’s -- The Gentrification Century
- Particularly Among the “Old Old”
- Can’t Last Forever, Because of
- Rectangularization of Survival Curve
 - AKA The “Compression” Phenomenon

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As discussed in Module 1, the number of citizens over 65 has continued to increase steadily throughout the century. Although many other factors affect the seniors’ housing market, the numbers do tell us something about the potential need for services.

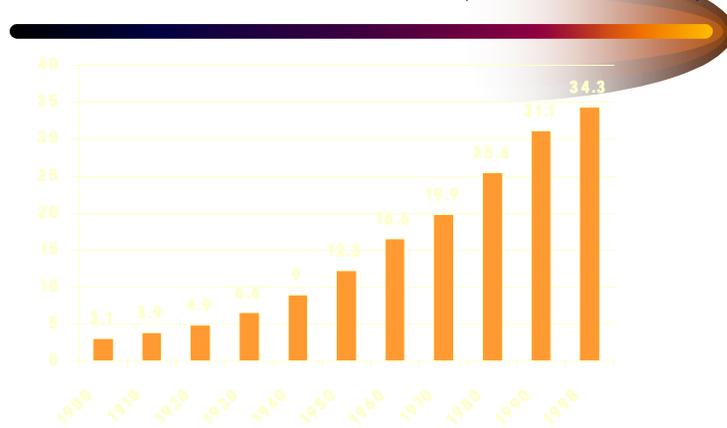
However, the word “potential” must be emphasized, for gross numbers don’t tell the whole story. Only by looking *behind* the numbers can we get a sense of the implications of aging for the seniors housing and care industries. For example, looking at the growth of the elderly in the country (normally

described as those sixty-five years of age and over) isn’t as instructive as looking at a different age cohort—those over 85. These are the elderly most likely to reside in seniors housing, at least in nursing facilities and assisted living.

NOTES:

The Johns Hopkins Bloomberg School of Public Health
“Managing Long-Term Care Services for Aging Populations”

*Growth in Elderly
(In Millions)*



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Even here, numbers that are even more encouraging do not tell us everything we need to know. Once again, *what do you know about potential customers' needs?*

An example: seniors drive less than those under 65, and many no longer drive at all. While the implications for car sales is obvious, what effect does this fact have upon seniors' housing? Possibilities:

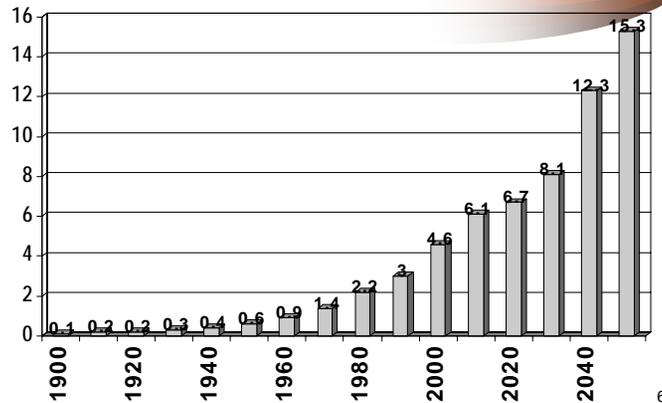
- How many parking spaces will be needed compared to apartment buildings and other housing facilities for younger adults?
- Will the facility need to provide transportation for residents going to doctor's appointments and other off-site activities?
- How will the facility deal with the possible liability should a resident have an accident?

Numbers, therefore, are useful only to the extent that they help developers structure their products.

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Growth in Elderly (85+)



Traditionally, 65 has been seen as the threshold into “seniordom.” Perhaps this perception has been based on the traditional retirement age and the point at which individuals became eligible for Social Security (although there have been changes in eligibility). However, this perception ignores two important factors:

- People who are 65 are not that different from other adult populations in terms of health, living arrange-

ments, financial status, and other factors. Most do not need specialized housing or care.

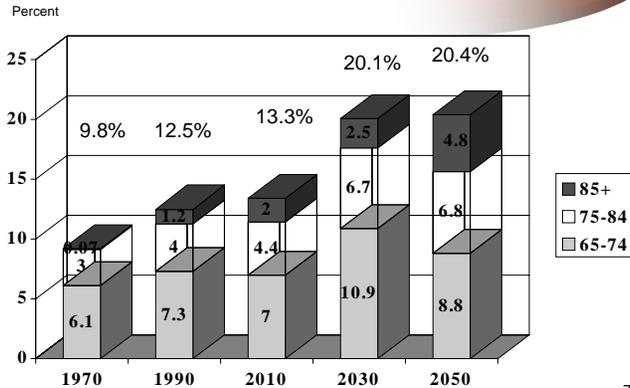
- Differences among individuals are at least as significant as age. Some 85-year-olds are vibrant, active, healthy, and fully independent. Some 65-year-olds are none of these.

The implication is developing a product for and marketing to 65-year-olds is very different than to a target population of 85-year-olds. Secondly, an assessment of the potential market cannot be based on the assumption that all people of a certain age are candidates for a given type of housing.

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Elderly as % of Population



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Life expectancy has increased dramatically over the past century, from 50 years in 1900 to 75+ today. This is particularly true of the oldest population cohorts:

- In 1900, 75% of the population died before age 65; in 1995, 70 % died after 65.
- The number of individuals who are 85 or older will increase from 2.3 million in 1995 to 16 million in 2050.

However, life *span* (as opposed to life *expectancy*) has remained fairly constant (at approximately 115 years). This is

a result of what the demographers refer to as the “rectangularization of the survival curve” (also known as the “compression phenomenon”).

NOTES:

The Fallacy of Numbers



- Numbers Important to the Extent They Isolate Trends
- Trends Important to the Extent They Predict
- Prediction Important to the Extent It Is Actionable

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For example...

Numbers: From 1980 through 1990, the demand for (and construction of) skilled nursing beds increased by approximately 2% per year.

Trends: By extrapolating these numbers and based on expectations regarding the continued need by seniors for facility-based long-term care services, one might have seen a continued trend into the future.

Predictions: There will be a continuing need for the financing of skilled nursing facilities.

Actions based on those predictions, however, would have proved faulty. Why? The predictions themselves were flawed in that they didn't take into account other factors, such as:

- Availability of assisted living and other alternatives to skilled nursing care
- Unexpected overall improvement in health (and decline in disability) among the senior population, thereby decreasing the requirement for skilled nursing care.

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Significance?

- 25 Years Added to Life Expectancy Since 1900
- But, Only 3 Years for Seventy Year Old
 - From 9 to 12
- Less Success in Combating Chronic Disease
- Is Length of Life Unaccompanied by Quality of Life?
- Are We Simply Older and Sicker?

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In other words, pure numbers don't necessary equate with need. While seniors are, indeed, healthier today than in past years, that phenomenon is neither universal nor dramatic. Increases in life expectancy are not as pronounced for those already in their senior years as for the newborn. Dramatic decreases in mortality are not accompanied by equally dramatic decreases in morbidity. 85-year-olds (for example) are not appreciably healthier now than their counterparts in the past. They just live longer.

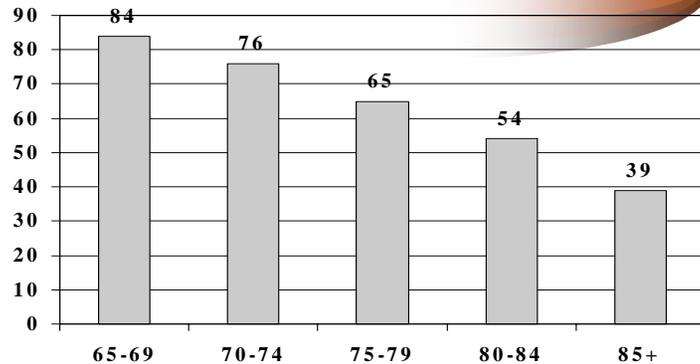
The implication for seniors' housing: designing facilities for long-term residents who need significant health care oriented toward chronic care needs and quality of life issues.

Factors affecting a senior's *quality* of life—health, security, social contacts, etc.—are often missing from their lives. What can be done to maintain that quality even as their life expectancy increases? How do we structure a product that meets those needs as well as more traditional health care concerns?

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Men Per 100 Women



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The market also needs to address gender.

Developers must design facilities and services that reflect the greater proportion of women in the seniors population. For example, most rooms should have (or allow for) “feminine” décor, and recreational activities must respond to women’s interest.

There are also social implications: Men who make it to old age will find many social opportunities available to them. Women, on the other hand, may well find themselves living the

life of the “elderly widow,” with deceased husbands and primarily (if not exclusively) female companionship.

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*Economic/Political
Implications*



- By 2030 Baby Boomers All 85+
- 70 Million Elderly
- 20% of the Population
- With Highest Growth Among “Oldest Old”
- Putting Incredible Burden on Support Systems
- Because the Elderly Live Longer, but Live Sicker

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Often referred to as “apocalyptic demography” or “voodoo demographics,” the social construction of catastrophe suggests that an increasingly aging population will place unbearable demands on the health care system.

The question is whether the costs of caring for an increasing number of seniors will so overwhelm economic systems that society will fall apart.

Seniors are less healthy than other population cohorts, thus requiring a disproportionate share of health care services.

By 2030, there will be 70 million elderly people in the U.S., the “oldest old” becoming the fastest growing group as the baby boomers reach 85 or older. 20% of the U.S. population will be over 65.

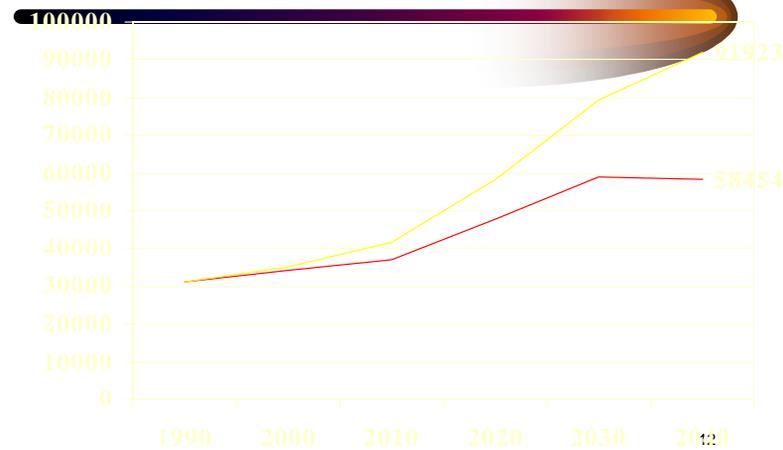
Their incomes, however, will not be able to support their consumption of health care services. Average household income goes down after age 54. The proportion of seniors (over 65) households with incomes below \$25K exceeds that of the general population; the percentage with incomes above \$25K is lower.

So, society will have to pick up the tab, but society can’t (or won’t) afford it.

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*Alternative Scenarios (65+)
In Millions*



But there are alternative scenarios.

This information, provided by the Congressional Budget Office (CBO), reflects the range of estimates regarding the senior population over the next 40 years. All of the estimates are reasonable and defensible, but they are based on varying assumptions, particularly in three areas:

- Birthrates
- Mortality rates
- Immigration

Any estimate requires an assumption regarding changes in birth rates and longevity, but in which direction and for how long? What about near-term immigration that will result in an increased number of seniors in future decades? A slight change in the assumptions can significantly change the result.

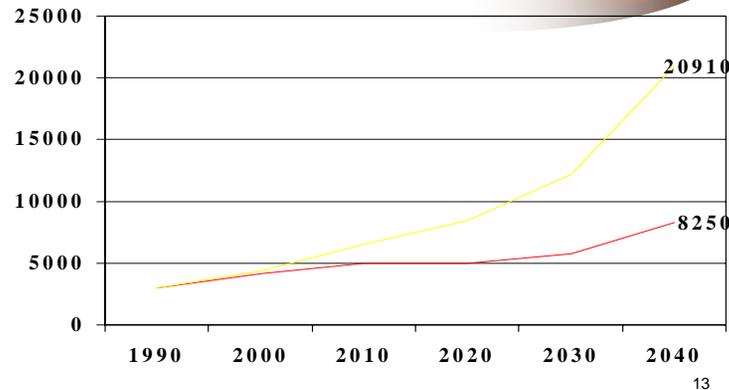
In estimating future populations, what you assume largely determines the results you get. Accordingly, you can select (or make) your own estimate based on your agenda. Those who support broader coverage by Medicare/Medicaid, for example, might select a lower estimate to show that future costs will not be prohibitive. Those seeking investors for a seniors housing development might choose a higher estimate to suggest future needs.

As we've already said, looking only at the numbers can be dangerous.

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*Same With the Oldest of the Old
(85+ in Millions by Year)*



Mortality estimates can be colored by numerous factors. For example, an extrapolation of current mortality figures to the future may not take into a variety of factors:

- Improvements in medical care that increase longevity
- Targeting of care to devote a greater portion of resources to individuals with less severe, more “curable” conditions

- Unanticipated large-scale illnesses, such as epidemics that might affect seniors because of their decreased resistance
- Factors that change the size of the general population and therefore reduce the proportion that is elderly; may include fertility and immigration

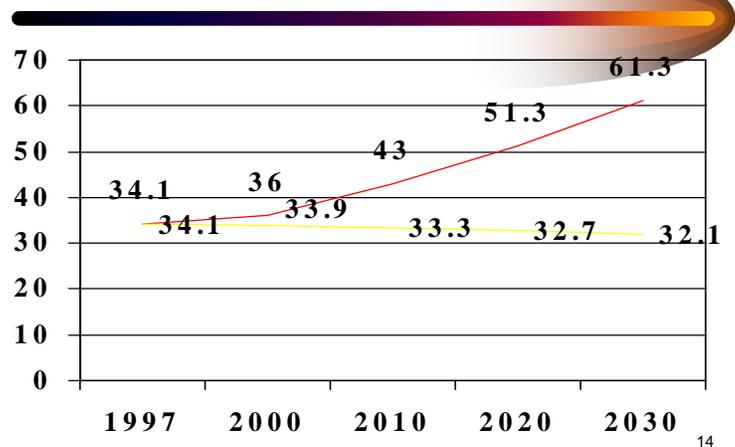
Fertility estimates are always uncertain, since it may be affected by factors ranging from the economy to education levels. Medical advances could also be significant, including cures for infertility and more effective contraception.

Immigration has historically had a major impact on the size and make-up of the U.S. population. However, immigration policy has always been politically motivated and subject to world events and popular opinion.

Projections of the future senior population must take numerous factors into account—particularly by the individual considering investment in or development of seniors’ housing.

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*CBO Projected Outlays as Percent of GDP
 (Based on 1% vs. 2% Growth Assumptions)*



Between 1996 and 1997, the Congressional Budget Office changed their estimates of federal outlays as follows:

Social Security	-10.4%
Medicare	4.6%
Medicaid	4.6%
Total Outlays	-8.5%
GDP	4.6%

Between 1997 and 1998, the CBO modified the estimates again by the percentages shown:

Social Security	-3.5%
Medicare	-17.3%
Medicaid	-35.7%
Total Outlays	-13.8%
GDP	3.5%

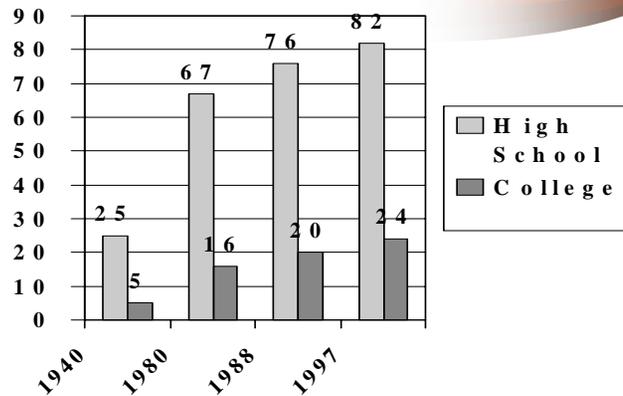
Was the change due to the availability of new information or discovery of a statistical error in previous estimates? No; the change in prediction was based strictly on use of a new growth assumption. Such a change could have a major impact on government policy; consider, for example, the difference in outlays for Social Security!

If estimates can change this much in just one year, long-term estimates are clearly risky and must be viewed with caution.

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Educational Attainment



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Increased education will also have an impact on social and economic trends (as well as health status). Education levels attained by seniors have shown dramatic increases over the past sixty years. Between 1960 and 1997, the average level of schooling increased from 8.3 to 13.4 years. Between 1970 and 1997, the per cent of elderly with a high school diploma increased from 28% to 66%. The number of those who had attended college increased to 24% (from 5% in 1940).

NOTES:

Older People with More Education:



- Tend to Be Healthier
- Have Fewer Disabilities
- Have Later Onset of Chronic Disease
- Have Lower Death Rates
- And Higher Income and Assets

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Educated seniors are not just healthier seniors. Education also affects their buying behavior, particularly when they consider the kind of facility they would consider living in.

Educated seniors tend to be more knowledgeable and have higher expectations of a facility. They are, for example, more likely to “do their homework” and come to the facility ready to ask more insightful questions regarding services, financing, and other factors. They may also expect a broader range of services, such as classes, transportation to cultural events—even Internet access.

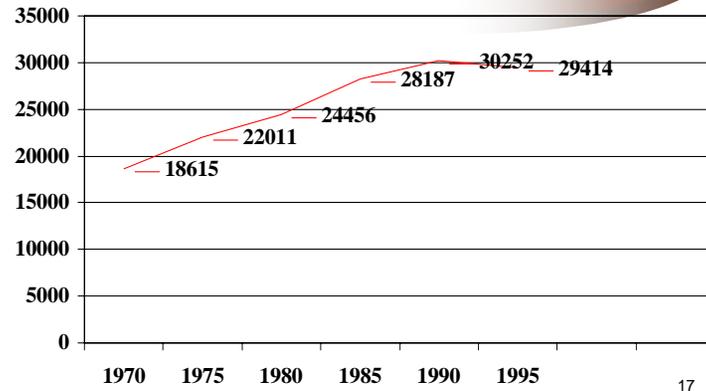
Location can be important, as well. Educated seniors might consider moving into a facility in a college town or near a metropolitan area. Such locations can provide them a wider range of activities than those in rural areas.

The development’s marketing approach must recognize these differences. While educated seniors are likely to be “more desirable” residents because of their better health and financial condition, attracting them requires a specialized, targeted approach.

NOTES:

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Income (1996 Dollars) for Married Household Over 65 With No Children Under Eighteen



Seniors also have more disposable income than in years past. Recall, however, these figures are averages and, like all averages, can be misleading. According to the Milbank Memorial Fund...

There is enormous inequality among older people--far more than any gap between them and the rest of the American population. While the median household income among elders aged 70 and over is \$15,624 in 1996 dollars, the comparable figure for those over 85—the population most likely to need long-term care—is \$9,439. The average household of a person over age 70 has less than

\$9,000 in financial assets (defined as total wealth minus housing and other real property assets). Those in the

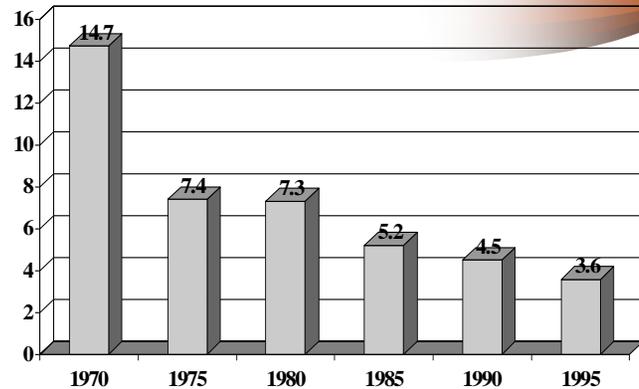
bottom 10% have no financial assets at all, while those in the top 5% have more than \$300,000.

Once again, the absolute number of seniors in a given area (or their average income) may not be as important as their specific characteristics.

NOTES:

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*Percent of Same Households in Poverty
(\$9,701 in 1997)*



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The increase in seniors' income is reflected in changes in their poverty rates. According to “Older Americans 2000: Key Indicators of Well-being,” in 1959, 35% of persons 65 or older lived in families with income below the poverty line. By 1998, the percentage had declined to 11%.

The relative poverty rates of the population 65 and older, persons of work age (18-64), and children under 18 have changed dramatically. In 1959, older persons had the highest poverty rate (35%), followed by children (27%) and working-

age persons (17%). By 1998, an equal percentage of the older population and working-age persons lived in poverty (11%); children's poverty level was 19%.

Among seniors, the poverty rate increases as they get older:

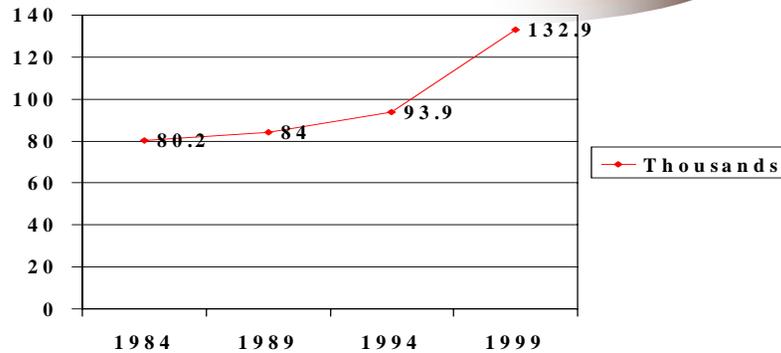
- 9% for persons 65-74
- 12% for those 75-84
- 14% for those over 84.

Seniors' poverty rates are higher among women than men (13% vs. 7%), among singles compared to married people (17% vs. 5%), and among minorities compared with non-Hispanic whites. For example, divorced black women 65-74 had a poverty rate of 47%, making them among the poorest groups in the U.S.

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Household Net Worth (Age 75+)



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On average, seniors’ assets break down as follows:

Percent Holding:	Average Worth:
Checking: 93%	\$ 5,000
Residence: 73%	\$80,000
Car: 73%	\$ 5,300
Insurance: 35%	\$ 5,000
CDs 34%	\$11,000
Stocks 21%	\$25,000
Real estate 17%	\$20,500
IRAs 16%	\$17,500
Savings bonds 15%	\$ 4,000

It is significant that the average senior’s largest asset—the residence—is not liquid. But it is becoming increasingly clear that the elderly are at least contemplating the sale of their residence so they can pay for housing and care. There are, of course, both practical and emotional barriers to such a decision.

NOTES: