A variety of government programs transfer cash or in-kind assistance to the elderly. These programs include efforts to which the elderly themselves have contributed through their payroll taxes or, less directly, through their income taxes. Most government assistance is in the form of cash through the Social Security and Supplemental Security Income programs or through the health insurance coverage provided by Medicare and Medicaid.

In the design of these aid programs, little attention has been devoted to their effect on the behavior of the elderly. The conditions for receiving assistance may alter one’s actions, as in the case of income, asset, and residence requirements for aid. In some instances, such as housing for the elderly, the nature of the directed consumption effort will affect the behavior of the recipients.

The particular actions altered as a result of aid often are direct matters of concern. For example, if work penalties lead the aged to retire from the labor force, society may lose productive individuals, and the aged will have lower levels of income. The altered actions of the aged also may provide valuable information for policy design. If the beneficiaries are willing to contribute to the cost of medical care or public housing, one can be more confident that these commodities are valued by the recipient than if there were no cost sharing.
The discussion begins with an analysis of the choice of the family structure and the role of government policy in these decisions. Although some of this discussion is necessarily speculative, my purpose is not to resolve the matter of the optimal family structure but to highlight the intractable problems involved in selecting policies of this type. The incentive effects of government policies are overviewed with special emphasis on programs that affect the family most directly. Although the actions taken by the elderly are often altered in response to government programs, this behavior is of interest wholly apart from potential inefficiencies that may be involved. In particular, the analysis indicates how information obtained from the elderly’s actions can be used to target assistance more effectively. The final section summarizes the broader implications for policy.

CHOICE OF HOUSEHOLD STRUCTURE

Although most of the elderly do not live with their relatives, substantial numbers do. Almost half of all unmarried elderly women and about one-third of single elderly men and married elderly live with relatives. About one-third of those elderly who live with their relatives bear at least their proportional share of the costs. The greatest dependency status for single women, while for the married elderly it is the nonelderly relatives who often are subsidized.

The potential benefits of multiperson households, usually involving a spouse or one’s relatives, are well known. As the economic theory of the family has shown, there are strong motivations for forming family units simply on the basis of the efficiency of the family as a productive unit (see Becker 1976). Services can often be provided more effectively on a joint basis, and many consumptive activities involve time inputs from more than a single individual. Several forms of in-kind assistance that are transferred by the government also are provided by the household unit, including medical care, shelter, and meals.

Nonelderly relatives also benefit in a variety of ways from the elderly, who assist in shopping, taking care of grandchildren, giving advice, and a variety of other activities summarized in Table 8.1. The diverse and widespread nature of this assistance suggests that the aged are quite active in the provision of services to nonelderly relatives. Even when these individuals do not share the same household, there appears to be

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1 Supporting data for this section are summarized in Viscusi (1979).
### TABLE 8.1
Ways in Which the Elderly Help Their Children or Grandchildren

<table>
<thead>
<tr>
<th>Category</th>
<th>Respondent group</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Elderly</td>
<td>Nonelderly</td>
</tr>
<tr>
<td>Give gifts</td>
<td>90</td>
<td>85</td>
</tr>
<tr>
<td>Help out when someone is ill</td>
<td>68</td>
<td>57</td>
</tr>
<tr>
<td>Take care of grandchildren</td>
<td>54</td>
<td>42</td>
</tr>
<tr>
<td>Help out with money</td>
<td>45</td>
<td>35</td>
</tr>
<tr>
<td>Give general advice on life’s problems</td>
<td>39</td>
<td>58</td>
</tr>
<tr>
<td>Shop or run errands</td>
<td>34</td>
<td>30</td>
</tr>
<tr>
<td>Fix things around the house or keep house</td>
<td>26</td>
<td>22</td>
</tr>
<tr>
<td>Give advice on raising children</td>
<td>23</td>
<td>40</td>
</tr>
<tr>
<td>Give advice on running a home</td>
<td>21</td>
<td>42</td>
</tr>
<tr>
<td>Give advice on jobs or business matters</td>
<td>20</td>
<td>31</td>
</tr>
<tr>
<td>Take grandchildren, nieces, or nephews into</td>
<td>16</td>
<td>21</td>
</tr>
<tr>
<td>home to live</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


considerable contact. Overall, of those elderly who have children, 55% have seen their children within the last day or so, while 81% have seen them within the last week or two (see National Council on the Aging 1975).

The economic rationale underlying the formation of household units is straightforward and will be discussed here within the context of the choice by the elderly and another party (e.g., their children) to live in the same household. Since this relationship would be terminated if either party chooses to do so, the joint arrangement will prevail only if the two parties prefer this arrangement to its alternatives. This underlying aspect of behavior is uncontrovertial. The possibility of preferences that are interdependent is not ruled out. A typical example of such interdependence is the case of an individual who would prefer to terminate the relationship if the other party were willing to do so, but otherwise is willing to continue.

Under rather broad circumstances, economists would conclude that the resulting arrangements are efficient (i.e., Pareto optimal). This household choice result is simply a variant of the Coase Theorem, which demonstrates the efficiency of a wide class of such bilateral bargaining arrangements.\(^2\) Interdependence of the parties creates no particular dif-

\(^2\) The classic article by Coase (1960) presents this result.
difficulties since the principal purpose of the Coase Theorem was to show that private bargains in cases of pollution and other externalities will be optimal.

The two principal requirements for efficiency are that there be no transactions costs to arriving at these bargains and that resources can be exchanged between the parties to compensate the other party for any loss in welfare due to a change in the course of action that would have been preferred if no such compensation were paid. This compensation need not be financial, as services within the household can be provided.

While this bilateral bargaining framework is instructive, within the context of family relationships it is likely to be quite costly to arrive at the types of implicit contracts associated with this theory. Most important is that as one moves from impersonal market transactions to relationships within the family, the role of transactions costs associated with arriving at solutions looms particularly large. These costs are unlikely to be symmetrical with respect to forming or dissolving relationships and are also likely to be inequitably divided between the parties.

Although social policies can potentially diminish such costs by shifting the decision from the parties themselves to the government, unless the direction and extent of the deviation of present arrangements from the socially optimal pattern is known with precision, one should be cautious in interfering with the choices of the individuals involved. Indeed, the principal implication of many of the chapters in this volume is that our knowledge of the relative welfare levels of individuals in different living contexts is still rather primitive. Even more rudimentary is our understanding of how altering the current structure of family relationships would alter the welfare of the affected parties.

Other considerations related to the effectiveness of the policy mix may lead one to consider intervention in this area. Society has instituted a number of programs to aid the aged, presumably because there is an externality to society at large from raising the elderly’s welfare. If influencing household choice were a particularly effective mechanism for increasing the well-being of the aged, one might wish to utilize it.

Suppose, for example, that additional tax incentives or other benefits are provided to household units with the desired characteristics and that, as a result, a substantially greater number of elderly would reside with their children. The welfare of the nonelderly individuals whose choices are altered presumably is no worse than before since they have chosen to make this decision. The well-being of the aged may be increased substantially.

The difficulty with outcomes in the absence of such incentives is that neither the elderly nor society at large may be able to compensate the
prospective nonelderly household members for the welfare gains that will accrue. The aged may be willing to incur higher Medicare deductibles or forego public housing in return for a subsidy that would alter household choices in this manner. However, these funds are not provided on a discretionary basis to be shared by the household. Cash assistance is less susceptible to this difficulty than is in-kind aid.

A second limitation of individual choices is that the relative attractiveness of different household structures may depend on what everyone else is doing. In particular, the relative rewards associated with the household choice are likely to depend on the household structures others have selected. For both non-elderly and elderly household members, the decision to live with one’s relatives is likely to be more attractive if many other households of this type exist. If sufficiently large numbers of children choose to live with their parents, others will do so as well. However, if very few do, they will not live with their parents either.

The group externalities reflected in this situation do not simply represent a desire to keep in step with one’s neighbors, as in the case of consumer fads. A shift in family structures will have a profound impact on social relationships outside the family. If individuals substitute activities with parents for those usually undertaken with friends who are not related, these other individuals’ choices and relationships also will be affected.

The substantial interdependency in these decisions further complicates the choice of the optimal government policy. Suppose that each particular policy is associated with some distribution of family structures. The policy choice’s most immediate effect is its direct influence on household choice. The magnitudes and desirability of these policy impacts are little understood. These uncertainties should discourage policymakers from major attempts to manipulate social behavior, particularly if these policies are not responsive to their performance. The less direct effect of these policies is through their pattern-setting role. If the government distorts choices sufficiently so that a modest number of households choose to divide into separate household units, the incentives for other households to do likewise will be altered, potentially leading to a complete unraveling in the present system of relationships.

The problem of valuing these outcomes is not at all straightforward. Since one’s preferred outcome depends on what everyone else is doing, there are severe problems of noncomparability. We need to know much more than we presently do about the nature and strength of individual

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3 For a general discussion of this class of issues, see Schelling (1978). The role of such behavior in influencing the employment patterns of the aged is detailed in Viscusi (1979).
preferences and their implications for social welfare to even begin ranking these outcomes in terms of their relative attractiveness. A great deal depends on the nature of the interdependency. If pattern-setting behavior reflects an ephemeral bandwagon effect, then we may feel quite differently than if it derived from more fundamental desires of people to form different kinds of relationships as their peers’ actions become altered.

Whether and how the government should undertake an active role in promoting social behavior is unclear. However, as will be argued in the next section, government policies already intrude into this area in quite a significant manner. Moreover, the implications of these impacts are not necessarily favorable.

INCENTIVE EFFECTS OF AID

Any assistance that the elderly choose to receive will increase their welfare and, in effect, make them richer. Some program benefits, such as subsidized housing or food, often will be valued by the aged at less than their dollar cost. Benefits that serve an insurance function, such as the annuities provided by Social Security or the health insurance provided by Medicare, may be valued at more than their actual cost by risk-averse consumers. The income effects generated by these efforts may alter a variety of actions, such as the elderly’s decision to work or their social relationships.

These changes in behavior deriving from the fact that program beneficiaries become richer are fairly unobjectionable. Unless it can be shown that too many resources are being transferred to individuals’ elder years, the altered behavior can be simply regarded as an optimal change in actions by the elderly in order to enhance their own welfare. Since most individuals augment government aid with savings and earnings of their own, it is doubtful whether society is in danger of making the aged too affluent.4

Ideally, assistance should be transferred to individuals on the basis of age or other measures of need that cannot be manipulated. Departures from the idealized situation of lump sum transfers invariably lead to altered actions by the recipient group in an effort to qualify for assistance. Chief among these disincentives may be the work penalties imposed by Social Security and other income assistance programs. At the program’s inception, an individual could not receive any Social Security

4 See Viscusi (1979) for empirical evidence. Whether or not these savings are large is not consequential. What is important is that the no-savings corner solution is not prevalent.
benefits if he or she had any earnings. These draconian measures were justified in part as an effort to remove the elderly from the labor force in the post-Depression period. Although the earnings test has been repeatedly liberalized, it remains harsh. The aged suffer a 50% marginal penalty on earnings (in addition to their usual taxes) for all earnings above $4500 annually. This penalty continues until all Social Security benefits are exhausted.

There is widespread evidence that individuals with higher levels of Social Security benefits are more likely to retire. This relationship is borne out by the analysis by Boskin (1977) of individual data for workers in their sixties, aggregative analyses of time series and cross-sectional data for various elderly cohorts by Viscusi (1979), and studies of early retirement by both Quinn (1977) and Boskin and Hurd (1977). Although these studies do not distinguish whether it is the income or substitution (i.e., incentive) effect of aid that is primarily responsible, there is a major danger if it is the latter influence that is operative. In that instance, the dependency status of the aged would be partially the result of government policies.

It is important to dispel the traditional argument in support of forced retirement for the aged. Forcing the elderly out of their jobs does not create jobs for the young, but primarily alters the macroeconomic scale of the economy. Short-run gains in employment of younger workers can only be obtained by continually lowering the retirement age—a strategy that would be viable only if the age of death is also reduced.

Present taxpayer restlessness over modest payroll tax increases undoubtedly will become more acute once the tax burden of supporting the elder years of the “baby boom” generation is imposed on the working population. Whereas the levels of Social Security benefits were previously immune from budget-trimming efforts, in 1980, policymakers seriously considered reducing the cost-of-living adjustment in order to balance the federal budget. The prospects for the elderly in terms of in-kind assistance are equally dim as the advent of national health insurance will deprive the elderly of their present privileged status as the principal subsidized consumer group in the health care market. Extrapolating from the post-Medicare experience, one would expect a dramatic increase in medical care costs and a decrease in quality. If the policy response includes rigid cost standards for medical care institutions, one might expect further lowering of the quality of care as well as greater sharing of medical care costs through coinsurance and deductible provisions. Unless the policies for influencing the welfare of the elderly are assessed

3 This intent of the framers of the Social Security program is discussed by Brown (1972).
and made more effective, there may be a rapid deterioration in the well-being of the aged population.

Concern with work incentives and other effects of policies should not be limited to financial concerns. For example, work is important to the elderly not only for the money it provides. Retirees citing the aspects of work they miss most include the friendships with co-workers and the feeling of being useful in their work (see Shanas et al. 1968). A gradual reduction in one’s work activity may be preferable to the abrupt transition the aged are now forced to make.

Analysts often attribute the absence of such flexibility in the choice of work hours to economic factors, such as the costs associated with coordinating the work efforts of individuals with shifts of differing length. This tendency to attribute the observed outcome to the market’s invisible hand may be unwarranted, owing to the influence of government programs in this area. The Social Security earnings penalty makes work attractive only in very large or very small amounts. Modest reductions in work effort will put the individual in the high marginal tax region in which the financial rewards from work are negligible. The importance of these factors is reflected in the distribution of the hours that the elderly work, which is concentrated in the very low part-time and full-time categories.\(^6\)

Household formation may be influenced directly by Social Security’s counterpart for the elderly poor, Supplemental Security Income. That effort reduces one’s benefits by one-third if the beneficiary is living in another’s house. Due to the strong intergenerational correlation in income status, this provision appears especially pernicious. Even if the aged are not subjected to elderly-in-the-house checks paralleling the man-in-the-house inspections for other welfare beneficiaries, the aged poor may forego potentially beneficial relationships with relatives in order to maintain their meager income status.

In-kind assistance programs have especially great potential for inefficiency when the goods and services provided to the elderly are different from those available to others. Although the modest levels of in-kind assistance limit the extent of this problem, there is a potential danger if, as suggested by the White House Conference on Aging, the elderly push for their fair share of each agency’s resources.

The subsidized housing efforts of the U.S. Department of Housing and Urban Development (HUD) illustrate this problem in especially dramatic fashion. In order to reap the government subsidy, the elderly must

\(^6\) See Viscusi (1979) for further discussion of the hours data.
live in the housing project apart from their relatives. The very nature of the in-kind transfer has a profound impact on the social relationships of those who receive it. The small role of HUD housing expenditures for the aged in the total aid package for the elderly (under 1%) should not lead one to dismiss this effort as unimportant. The predominantly urban poor elderly who are directly affected may be much more significantly influenced than the modest outlays would suggest.

The considerably larger in-kind assistance provided by Medicare and its companion efforts involve more subtle, but undoubtedly more far-reaching impacts. Since the program's inception, the relative subsidies have favored inpatient care relative to outpatient care. Patients choosing inpatient care incur a deductible amount of $144, after which there is no charge for hospital care until the sixty-first day, when the patient must bear $36 per day until the ninetieth day of care. In contrast, for outpatient care the individual incurs a $60 deductible and must bear 20% of all subsequent costs.

Even if both modes of care were equally costly, the inpatient care would impose fewer out-of-pocket costs on the individual for all care with a total cost above $420. In the usual situation, in which inpatient care is considerably more expensive, the differential costs for society may be quite dramatic. Perhaps the most striking inefficiency is that an individual who has been hospitalized and exceeded his or her deductible faces a marginal cost of zero for inpatient care. The prolonged hospitalizations that result are considerably costlier to society than are outpatient services.

Presumably this bias is justified on the grounds that hospitalized individuals have greater needs and are more deserving of assistance. From the standpoint of efficient utilization of Medicare resources, this policy is clearly misguided, since individuals are encouraged to use relatively more expensive inpatient care whenever there is a choice in treatment modes.

By promoting institutionalized care of the elderly, the relative subsidies for inpatient care may affect the contact the aged who are ill have with their friends and families. This problem appears to be especially acute for the terminally ill, who are deprived of the ability to die with dignity in their homes, and for nursing home residents, who in many instances receive low quality care, in part because the governmental subsidies insulate many of these institutions from competitive pressures.

Although it is easy to cite inadequacies of any in-kind assistance structure, the inherent difficulties in targeting such aid efficiently should not prevent one from examining ways in which these policies can be
made more effective. In the next section, I will consider how one might approach these difficulties to promote the interests of the elderly and those of the taxpayers at large.

EFFICIENT TARGETING OF SERVICES

The principal task in designing an optimal cash transfer policy is to develop a program structure that will serve as an annuity for all aged, avoid the problem of adverse work disincentives, and also support the well-being of those most in need. Reconciling these three objectives has been quite difficult. However, the effectiveness of government programs has been enhanced through a diversified policy mix that includes a special income transfer program for the elderly poor—Supplemental Security Income.

The difficulties encountered in designing effective service transfers for the aged are perhaps even more complex. The central problem is that the value of the services to the recipient is unclear. If, for example, medical care were provided free to the aged, there would be no incentive to avoid discretionary expenditures that have little or no effect on one’s health status. Moreover, when choosing between alternative modes of care with the same implications for one’s health, such as inpatient and outpatient treatment, there would be no incentive for the patient, the doctor, or the hospital to take full account of the ultimate cost to society when making their decisions.

Problems of this type are particularly acute with respect to a subsidized home care option. Many individuals currently receiving nursing home or hospital care might find a government-subsidized home care option more attractive. However, other aged who do not currently receive care also might wish to take advantage of these services. The demand is likely to be especially great if the services are not limited to health care delivery activities that would be desirable only to those in need of care. The provision of meals, assistance with household duties, and perhaps the companionship provided by home care assistants may lead to a substantially more costly health care effort than the current program.

The monitoring difficulties associated with home care are more severe than those usually encountered, although the nature of the problem is quite similar. The fundamental problem is to target the services provided in an efficient manner. For any particular budget level, how should the program best be designed to promote society’s objectives?
These concerns can be divided into two broad categories. First, one should attempt to promote individual well-being as it is perceived by the beneficiaries. Other things being equal, one would like to provide the services valued by the elderly themselves. Second, in a publicly supported program, one should attempt to promote the kinds of policies preferred by the taxpayers who support it. The range of government health programs suggests that there is a widespread concern with individual health status and that programs should be directed at improving individual well-being even if the recipient might not have chosen to allocate his or her funds in that manner.

The pivotal question for policy design is how to structure a mechanism for rationing services that best promotes these two concerns. Perhaps the least attractive method of screening out deserving recipients of aid is to make prior institutionalization a precondition for assistance. Such efforts will only distort individual health care choices in much the same manner as Medicare provisions presently encourage needless hospitalizations in efforts to qualify for subsidized nursing home care.

A second possibility is to provide assistance based on ailments that can be monitored. To some extent, distinctions along these lines are already made. Cosmetic surgery and private rooms are excluded from subsidized Medicare coverage. Moreover, dental care is not covered, presumably because it does not affect one’s mortality prospects and because much dental care is of a discretionary, cosmetic nature.

Similar restrictions might be imposed when determining eligibility for home care or other services. Thus, the home care option might be made available to those with readily monitored ailments, such as those suffering from terminal illnesses or a disabling stroke. However, individuals omitted from coverage might be regarded as also meriting assistance. These persons include many with ailments whose presence or severity is difficult to verify. Arthritis victims and individuals with back problems are typical examples. Using “monitorable” ailments as a criterion for assistance may be helpful in certifying small segments of the population as meriting assistance, but it will not be completely effective in identifying all individuals for whom medical care would be beneficial and highly valued.

The usual proposal to discourage inefficient utilization of health care services is to employ deductible and coinsurance provisions. All expenditures up to the deductible level are borne by the patient so that the problems involving excessive subsidies from society do not arise. Coinsurance provisions require that the patient bear some fraction of health care costs; this coinsurance rate often varies according to the type of care (e.g., inpatient or outpatient) and the level of expenditure.
The disadvantage of higher deductible and coinsurance rates is that they reduce the risk-spreading function of insurance, partially undermining the principal rationale for such programs. The poor may be especially hard hit by these provisions since they are least able to afford the out-of-pocket expenses needed to receive care.

Here I will propose an alternative approach to rationing medical services. Unlike the usual cost-sharing arrangements, it is able to promote efficient utilization of medical resources without putting the poor at a relative disadvantage.

It is instructive to begin with the preferences of a hypothetical beneficiary. Suppose that the individual is either healthy or ill and that only if he or she is ill will medical care be potentially desirable; additional expenditures may enhance the probability of becoming healthy. The primary difficulty is that one cannot monitor the effect of health care expenditures on the probability of returning to the healthy state. (In a more general framework, the underlying initial health state could also be uncertain.) If health care were fully subsidized, the beneficiary might opt for all available care. As the level of costs shifted to the patient increases, one can be more confident that the expenditures are effective in improving the chance of becoming healthy, but the risk-spreading aspects of insurance are sacrificed.

The hypothetical taxpayer bears the share of costs above the deductible that are not covered by the coinsurance rate. For simplicity, neglect all distributional concerns so that the optimal medical insurance structure can be distinguished from income transfer motivations. In the case of an ill patient receiving treatment, the taxpayer faces a similar lottery since he or she prefers that the individual would become healthy but would like to limit the extent of the public subsidy. The difficulty from the standpoint of the taxpayer is that he or she cannot monitor the functional relationship between the level of health care expenditures and the probability that these allocations will enhance the patient’s health.

The structure of the optimal policy design problem is as follows. The government selects the deductible and coinsurance level that will maximize the expected utility of the representative citizen. The taxpayer’s well-being is diminished by an increase in his or her contribution to the medical care but is enhanced by the beneficial effect that health care has on the patient’s welfare. The deductible and coinsurance provisions affect

7 The mechanics of this problem represent an extension of the model developed by Zeckhauser (1970). The principal difference is that the income of the recipient is allowed to influence the optimal plan structure, and taxpayer preferences with respect to the patient’s medical status are recognized.
the medical care decision by the patient, thus influencing the total health care expenditure as well as the public share of any given level of expense. The government is strategic in its plan design since it takes these reactions into account in structuring the optimal policy.

A principal difference with earlier analyses is that the heterogeneity of the beneficiaries is taken into account. Under a wide range of assumptions, one can demonstrate that when placed in identical medical situations, those with higher incomes will choose to spend more on their care. This relationship is also borne out empirically.

As a consequence, the optimal degree of cost sharing will increase as the income level of the beneficiary rises. The reason for this discrepancy is that one can be more confident that, for a given level of expenditure, medical care will enhance the welfare of the poorer recipient. If both rich and poor patients faced the same cost-sharing provisions, wealthier beneficiaries would opt for a greater degree of discretionary medical care.

The usually cited problem of the inordinate burden of cost-sharing provisions on the poor is not necessarily due to a neglect of distributional concerns. Completely apart from equity considerations, the optimal plan structure will vary the degree of cost sharing positively with the beneficiary’s income, since the positive income elasticity of demand for medical care affects the informational content (i.e., whether or not the expenditures are productive) of the out-of-pocket expenditures. To avoid work disincentive effects, the wealth measure used could be a lifetime wealth index, such as that used in computing Social Security benefit levels.

No policy alternative will be completely free of shortcomings, since the inability to monitor individuals’ health status and the effectiveness of expenditures in enhancing their welfare inevitably leads to a variety of compromises in an effort to hold down program costs while meeting the elderly’s needs. In making these tradeoffs, the heterogeneity of elderly beneficiaries should be taken into account when structuring the policy. The benefits will not be targeted efficiently if the information

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1 Consider utility functions conditional on one’s health, that is $U_i(y) = \text{the utility of money } y \text{ when one is healthy}$ and $U_j(y) = \text{the utility of money when one is ill}$, where $U_i > U_j$, $U_i' \geq U_j' > 0$, and $U_i'' \leq U_j'' \leq 0$. Let the probability that health care expenditures $x$ make the individual healthy be $p(x)$, where $p' > 0$ and $p'' < 0$. The deductible $d$ and the coinsurance rate $c$ imply that an expenditure of $x$ reduces the consumer’s initial assets $A$ to a level $A - d - c(x - d)$ unless the deductible is not exceeded, in which case the individual’s wealth is $A - x$. In each of these situations, differentiation of the first-order conditions for the optimal $x$ implies $\delta x/\delta A > 0$. The health care expenditure level chosen increases with one’s assets.
conveyed by the expenditures of differently situated elderly citizens is not incorporated in the policy design.

CONCLUSION

Unlike many policy choice problems, not only are the quantitative effects of different policies not fully understood, but the objectives for these policies are also unclear. Our understanding of the effect of different household structures and other relationships on individual welfare is rather meager. Moreover, the extent to which these relationships can be altered by policies is largely unknown, both because the impacts of past policies on the elderly’s behavior have not been adequately explored and because there has been no deliberate experimentation with these policies in an attempt to identify particularly effective modes of intervention.

It is almost inevitable that these programs will alter many actions taken by the aged, either because the beneficiaries’ wealth is affected or their incentives are altered by assistance. There should be a continuing reexamination of government programs to determine which of these impacts has a substantial, deleterious effect on the aged’s welfare and which provisions can be altered to improve the effectiveness of policies.

The analysis of the efficient targeting of assistance also suggested that the changes in the actions taken by the elderly in response to policies are not of interest solely because of the potential inefficiencies that may be involved. The decisions made by the aged often convey important information that can be used in designing a more effective policy.

Consideration of health care choices by the aged, for example, suggests that present policies might be improved by linking the degree of cost sharing to one’s income status. This variation in the current approach would be more effective in directing assistance to the individuals for whom government subsidies are most beneficial. The superiority of this approach to current policies would be enhanced if one also wished to express a distributional preference for the elderly poor.

REFERENCES

8. AN ASSESSMENT OF AID TO THE ELDERLY


