

Brandeis University

Maurice and Marilyn Cohen Center for Modern Jewish Studies

Hardship And Needs Of Elderly Hased Clients: An Analysis Of Clients Served By Hased Service Centers In Russia & Ukraine

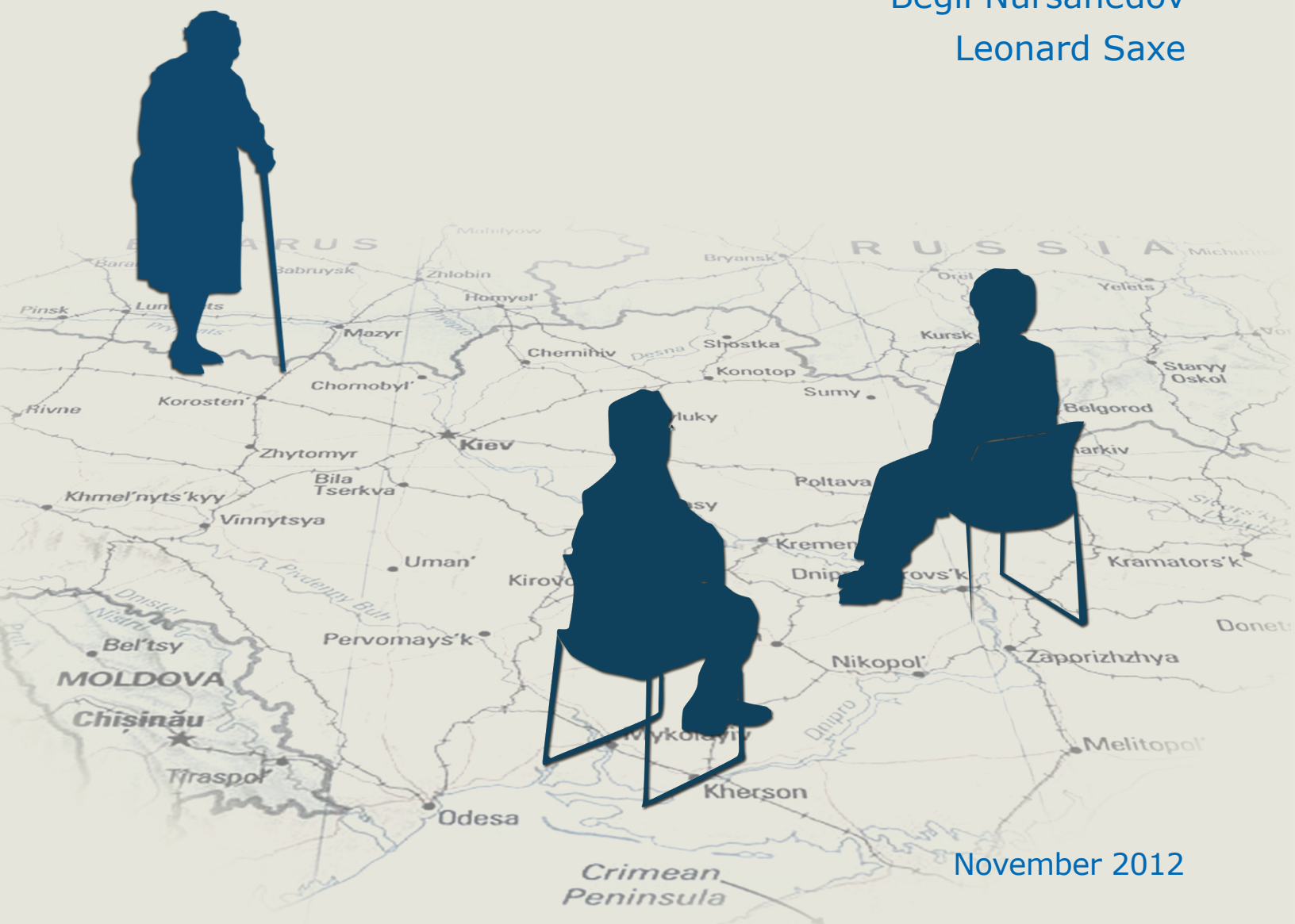
Elizabeth Tighe

Raquel Magidin de Kramer

Dina Bleckman

Begli Nursahedov

Leonard Saxe



November 2012

© 2012 Brandeis University
Maurice and Marilyn Cohen Center for Modern Jewish Studies

Additional copies of this publication are available from:
Maurice and Marilyn Cohen Center for Modern Jewish Studies
Brandeis University
Mailstop 014
Waltham, MA 02454-9110
781.736.2060
www.brandeis.edu/cmjs

The Cohen Center for Modern Jewish Studies, founded in 1980, is dedicated to providing independent, high quality research on issues related to contemporary Jewish life.

The Cohen Center is also the home of the Steinhardt Social Research Institute (SSRI). Established in 2005, SSRI uses innovative research methods to collect and analyze socio-demographic data on the Jewish community.

Acknowledgments

The authors gratefully acknowledge the American Jewish Joint Distribution Committee (JDC) for their support of this research. We are especially grateful for the support for this research we received on our site visits from JDC directors, Esther Katz and Alik Nadan, their staff, local Hased directors, local representatives of Jewish Family Services and Jewish Community Centers, and to the people of the Jewish communities of Dnepropetrovsk and Melitopol who shared with us their stories of life in these “transitional economies” and their new-found freedom to embrace their Jewish traditions. In addition, we are grateful for the insights on Jewish life in Dnepropetrovsk shared with us by Zelig Brez, Director of Dnepropetrovsk Jewish Community Charitable Foundation and Rabbi James Morgan of the Jewish Communities Relations Council of Boston. At Brandeis University, we would like to thank our colleagues at the Cohen Center for Modern Jewish Studies (CMJS) and the Steinhardt Social Research Institute. In particular, we thank Micha Rieser who assisted with analysis of data and preparation of this report and Deborah Grant for her careful review and editing skills. The views expressed in this document are our own and are not, necessarily, those of the Joint Distribution Committee.

Table of Contents

List of Figures and Tables.....	iv
Executive Summary	1
Introduction.....	5
Background.....	6
How do the Pension Systems Compare?	7
Old-Age Pensions	7
Disability Pensions.....	7
Survivor Pensions	8
Summary/Challenges	9
Status of Elderly Population in Russia and Ukraine	11
Macro-Indicators	11
Economic Indicators	11
GDP post-2008.....	11
Consumer Price Index	12
Population Indicators	13
Aged Dependency Ratios	15
Elderly as Proportion of Total Dependent Population	16
Life Expectancy and Mortality.....	17
Life Expectancy at Age 60	17
Health System	18
Summary	22
Condition of Elderly within Regions	23
Former Soviet Union.....	23
Demographics.....	23
Proportion Female	24
Age Distribution	25
Economic and Social Conditions	25

Pensions	25
Living Situation.....	26
Health Status.....	26
Activities of Daily Life	27
Services Hased Clients Received	30
Services by Disability Level.....	31
Summary	34
United States	34
Demographics.....	35
Living Situation.....	36
Health Status and Services.....	36
Comparative Analysis.....	41
Demographics	41
Economic and Social Conditions.....	42
Health Status & Home Care.....	49
Summary	51
Discussion.....	53
Notes	57
References	59

List of Tables

Table 1: Economic Indicators: 2010	11
Table 2: Total population, Percent Aged 65 Years and Older, and Proportion Female: 2010.....	14
Table 3: Life Expectancy, 2009.....	17
Table 4: Life Expectancy at Age 60, Males and Females, 1990, 2000, & 2009	17
Table 5: Number of Elderly Clients: 2004, 2006, 2011	23
Table 6: Percent by Age Group	25
Table 7: Median Monthly Pension Income: Elderly Hased Clients: 2011	26
Table 8: Living Situation: 2011.....	26
Table 9: Vision, Hearing, & Mobility Problems: 2011.....	27
Table 10: Functioning, Activities of Daily Life: 2011.....	29
Table 11: Percentage of Clients Receiving Services in 2011 ^a	30
Table 12: Percentage of Clients Receiving Services by Functionality	31
Table 13: Average Monthly Home Care Hours by Functional Limitations	32
Table 14: Characteristics of Population 65 Years and Older in the United States.....	35
Table 15: Children and Living Situation of Population 65 Years and Older in the United States.....	37
Table 16: Health of Population 65 Years and Older in the United States	38
Table 17: Monthly Home Care Hours 2011 by Type of Home Care Worker in United States.....	39
Table 18: Home Health Care Expenditure for Elders in United States.	40
Table 19: Demographic Comparisons: Elderly NNV Hased Clients vs U.S. Elderly	41
Table 20: Median Monthly Pension Comparisons: NNV Hased clients vs. U.S. Elderly.....	42
Table 21: Consumer Expenditures Across Countries (International Dollars): 2011	44
Table 22: Health Status & Home Care Utilization: Hased NNV Clients 2011 to U.S. Elderly.....	49

List of Figures

Figure 1. GDP: Annual Percentage Growth Rate, 2001 to 2010.....	12
Figure 2. Consumer Price Index, 2005 to 2010.....	13
Figure 3. Female Population Aged 65 Years and Older	14
Figure 4. Population Aged 65 years and Older Relative per 100 Working Aged Population	15
Figure 5. Population Aged 65 years and Older in Proportion to Total Dependent Population.....	16
Figure 6. Health Expenditures per Capita, 1995 to 2010.....	18
Figure 7a. Public Health Expenditures as Percent of GDP, 1995 to 2009.....	19
Figure 7b. Private Health Expenditures as Percent of GDP, 1995 to 2009.	20
Figure 8. Private Households' Out-Of-Pocket Payment on Health.....	21
Figure 9. Nursing and Elderly Home Beds per 100,000 People: 1990 to 2010.	21
Figure 10. Percentage Elderly Clients in Russia and Ukraine Who are Female, 2011.....	24
Figure 11. Average Monthly Home Care Hours for NV and NNV clients.	33
Figure 12. Average Monthly Home Care Hours of Service Received.....	39
Figure 13. Median Monthly Pensions for NNV Hesed Clients in Russia and Ukraine.	43
Figure 14. Comparison of Consumer Expenditures to Pension Income	46
Figure 15. Average Monthly Home Care Hours by Type of Home Care Worker: FSU vs. United States.....	50
Exhibit 1: Costs to Citizens in Ukraine for use of Social Services	48

Executive Summary

The countries of the Former Soviet Union (FSU) are the home today for a substantial number of Jews, many of whom live in poor, economically disadvantaged communities. Throughout the FSU, the American Jewish Joint Distribution Committee (JDC) has supported the development of Hesed welfare and Jewish community centers to assist in the provision of services to Jews in need and to support the renewal of Jewish life after years of suppression. Funding for welfare assistance is provided through the support of the Harry and Jeanette Weinberg Foundation, International Fellowship of Christians and Jews (IFCJ), World Jewish Relief, Jewish Federations from across North America, The Maurice and Vivienne Wohl Charitable Foundation and private funders. Significant resources from the Conference on Jewish Material Claims Against Germany and from the Swiss Banks Settlement have contributed to ameliorating some of the needs of Jewish elderly who were victims of Nazi persecution in these regions. As the numbers of Nazi victims dwindle over time, there remains tremendous need among the large number of elderly who were not victims of Nazi persecution in these regions (non-Nazi victims). The present report is designed to review the current economic, health, and social conditions of these elderly Jews in need in the FSU and to compare their circumstances, as best possible, to their counterparts who live in western countries such as the United States.

Data from a large number of sources are reviewed and analyzed, including national statistics, national and local surveys, and client-level data. The data indicate clearly that, in view of demographic composition,

as well as economic and social conditions, elderly Jews in the FSU have tremendous needs for supportive services funded by philanthropy compared to their peers in the United States. The comparisons also highlight the disparities in available care among those most in need. Within the FSU, our focus was on the countries of Russia and Ukraine, where the largest numbers of Jews who receive services through Hesed centers live. Limitations on available data are noted in the report.

There is a clear need for external support for basic health and social services for elderly Jews in the FSU. Twenty years after the collapse of the Soviet Union, there is not an adequate safety net for the elderly. The situation is in flux and there are unique challenges associated with understanding service delivery in societies that are in transition. The available data on pensions and living circumstances make clear that the economic situation for elderly in the FSU who seek Hesed services is dire. Faced with increasing costs for basic needs such as utilities and food, along with health services including essential medicines, quality care and homecare, the pension amounts that Hesed clients rely on are inadequate to meet their needs.

Worsening economic conditions within FSU countries present significant challenges for the public sector to meet the needs of their aging populations and provide necessary supportive services.

- GDP per capita for the United States (\$47k) is 2.5 times larger than Russia (\$20k) and seven times larger than Ukraine (\$7k).

- The economic crisis of 2008 led to a decrease in GDP by 15% in Ukraine and 8% in Russia, compared to just 4% in the United States.
- Consumer costs have increased at much faster rates in FSU countries than in the United States. In 2010, consumer costs in Ukraine had nearly doubled since 2005, and had increased by 63% in Russia. In comparison, consumer costs in the United States increased 12% between 2005 and 2010.
- The increased costs represent increased burdens on consumers for basic needs such as food, shelter, and energy. Such large price fluctuations are especially difficult to manage on pension incomes. In both Russia and Ukraine estimates of household expenditures are more than twice the reported pension incomes. If based to government estimates of minimum subsistence levels, nearly 100% of one's pension income in Ukraine is absorbed by minimum subsistence costs and nearly half of pension incomes in Russia.

A lack of public and private health expenditures in FSU countries results in increased burdens on individual household incomes to cover health care costs:

- Adjusted for purchasing power parity (PPP), total health expenditures per capita in the FSU are far below those of the United States. In 2010, expenditures in Ukraine were \$500 per capita and in Russia, \$1000 per capita. In the United States, by comparison, expenditures were \$8,400 per capita.
- Public expenditures as percent of GDP, which indicates the total government spending on health, including social health insurance programs, has hovered

below 4% of GDP in the FSU countries compared to nearly 8% of GDP in the United States. Further, in the United States, private expenditures—which include household out-of-pocket spending, private insurance, charitable donations and payments from private corporations—are nearly equal to or exceed public expenditures, whereas in Russia and Ukraine, private expenditures are lower than public expenditures. This indicates that there are fewer private resources available to supplement the lower percentage of public resources.

- Out-of-pocket expenditures are more than three times greater in Ukraine than in the United States. Over 40% of health care costs must be paid out-of-pocket in Ukraine and 30% in Russia compared to approximately 13% in the United States.

Key findings of the report which relate to those elderly Jews who are non-Nazi victims are:

Elderly Hased clients have substantially less income to meet increased costs:

- Based on data from the International Comparison Program (ICP, 2005) on actual consumer expenditures, nearly all— 99% of elderly non-Nazi victim Hased clients in Russia and 97% in Ukraine have pensions below estimated expenditures. Estimated expenditures are around three to four times as high in the United States (\$2,706) than in Russia (\$958) or Ukraine (\$679). Pension incomes, in contrast, are three to four times lower compared to social security income in the United States and six to ten times lower than total median household income for elders in the United States (\$2,994).

Elderly clients have significant limitations in their ability to perform daily activities such as dressing, personal care, taking medicines, preparing meals, and taking care of finances:

- Nearly 10% of clients in both Russia and Ukraine are limited by 60% or more in their daily functioning, which means that they need significant assistance to perform daily tasks ranging from personal care—such as bathing, dressing, continence, and eating—to personal finance, housework, and taking essential medicines.
- Nearly 26% of clients in Ukraine and 16% in Russia have at least one functional limitation. Of these clients:
 - ◊ 35% in Russia and 27% in Ukraine require assistance with personal care, such as bathing.
 - ◊ A majority (74% in Russia, 67% in Ukraine) require assistance preparing meals.
 - ◊ 30% in Russia and 24% in Ukraine require assistance with managing medicines.
 - ◊ 68% overall (76% in Russia, 63% in Ukraine) have impaired vision.
 - ◊ A large proportion are hearing impaired (42%), and have limited mobility outside the home (49%).

Elderly Hesed clients are predominantly women who live alone:

- Over two thirds of elderly clients in FSU countries are women (e.g., 71% in Russia, 68% in Ukraine), compared to 56% among elderly in the United States.
- Average life expectancy in Russia and Ukraine is 68 years (62 years for men,

74 years for women), more than 10 years fewer than in the United States.

- Over a third of elderly clients live alone: 38% in Russia live alone and 35% in Ukraine.
- The high ratio of older women to older men living alone and with fewer children nearby has implications for psychological well-being as well as for needs for supportive services.

Elderly Hesed clients have substantially less access to care compared to elderly in the United States:

- There is a large disparity in the average number of hours of Home Care service that Hesed clients receive compared to elderly in the United States who have similar levels of need. Elderly Home Care clients in Russia and Ukraine receive nearly 10 times fewer hours of care (~ 24 hours/month) compared to their counterparts in the United States (~ 220 hours per month), and nearly 20 times fewer hours than elderly in the Northeast Metropolitan areas (~ 417 hours/month).
- Within the FSU, non-Nazi victims receive fewer Home Care hours compared to their counterparts who were Nazi victims. In both Russia and Ukraine, non-Nazi victims most in need of Home Care services, that is, those with the highest degree of functional limitations, receive on average up to 40 fewer hours of Home Care per month than Nazi victims.
- For care provided by Home Health Aides, the type of care most similar to that provided to Hesed clients, those in the FSU receive nearly five times fewer hours than elderly in the United States

and 10 times fewer hours than counterparts in Northeast Metropolitan areas.

- Twelve percent of elderly who receive Home Care in the United States receive 24 hours of care per day. No elderly served by Hased centers receive this level of Home Care.

The story that emerges from comparative analysis across nearly all indicators is that:

- Elderly Jews in the FSU experience clearly higher levels of disadvantage than their counterparts in the United States.
- The level of services Jews in the FSU receive given their level of need is far less adequate to meet their needs than their counterparts in the United States.
- In FSU countries, elderly have less access to state-supported social services, whereas Jews in non-FSU countries have access both to better government-supported social service networks and, importantly, to additional social service networks within well-established local Jewish communities.
- The economic turbulence and instability in Ukraine may be far greater than that experienced in Russia, but both countries face challenges with respect to effective funding of pension systems.

Introduction

The present report is a snapshot of the current economic, health, and social conditions for Jewish elderly in the Former Soviet Union (FSU). Included in our review is an assessment of existing services and programs for this population. We compare the conditions and services for Jewish elderly in Western countries and highlight where there are gaps between needs for services and the resources available to meet needs. Unlike previous reports prepared by the Cohen Center for Modern Jewish Studies at Brandeis University which focused primarily on international comparisons of the needs of Nazi victims (Hahn, et al., 2004; Tighe et al., 2007), the current analyses highlight the needs of other elderly, Non-Nazi victims (NNV). Although not subject to Nazi persecution, many Jewish elderly in the FSU struggle to survive amidst levels of economic disadvantage that are unlike those of Jewish elderly residing in regions such as North America and Israel. The global economic crisis in 2008 eradicated some of the advances in economic stability that had been made after the collapse of the Soviet Union in 1991, especially for pension systems in these countries (Gora, Rohozynsky & Sinyavskaya, 2010; OECD, 2011). Many of the pension reform efforts begun since the transition to new economies have not matured sufficiently to affect the reliance of most pensioners on the government-funded pension systems as their primary safety net against the risks of poverty. The impact that economic turbulence and economic policies have on national accounts greatly affects the resources available to fund pension systems and, concurrently, the social programs that aging populations rely on, such as the health

and social welfare systems.

The focus on Non-Nazi victims derives in part from the potential disparities in services and resources available. As described by Forrester (2011):

The Hesed staff see both groups as needing similar levels of support, and have to discriminate because of the terms of funding provided, rather than because of major differences in needs between NVs and NNVs, in relation to their living conditions, health and need for support via food packages and medicines. (p. 30)

Overall, per capita spending by the JDC, based on the total 2012 budget for welfare across all services provided in Russia and Ukraine, averaged \$283 for non-Nazi victims in Russia and Ukraine compared to \$1,232 for Nazi victims (Heetner, September 18, 2012).

Our report is based on analyses of the cross-country intake and case management database maintained by the Hesed centers and the JDC.¹ Russia and Ukraine are examined as exemplars of conditions in the FSU. Characteristics of all clients who received services during 2011 were examined. The situation of these elderly is compared to their similarly aged counterparts in the United States.²

Our understanding of the use of Hesed data to describe the situation of Non-Nazi victims in the FSU was informed through site visits to eastern Ukraine—Dnepropetrovsk and Melitopol—and Moscow, Russia. The key

issues assessed on these visits were:

- the representativeness of Hesed clients of all Jewish elderly
- clarification of how constructs were defined by those who collect the data, particularly important for comparison to U.S. sources of data

We were especially interested in learning more about the local contexts in which the data were collected, including possibilities of alternative sources of data that could be brought to bear to understand and describe the needs of elderly in these regions. Our observations and the insights gained on these visits are incorporated into the report, in particular, in the discussion of results and recommendations.

Background

The social and health conditions of Jewish elderly in the FSU are greatly affected by the state of government-funded pension systems. These systems, though never fully effective even during Soviet times and, although in the process of reform, have deteriorated since the early 1990s (Gora, et al., 2010). Whereas the pension system of the Soviet Union provided pensions to all workers in state-owned firms and collective farms, modern pension systems seek to provide assistance to the entire population of pensioners. Although there are challenges to all pension systems, notably population aging and increased demands on health and social systems associated with a larger share of the population living beyond working age, for countries such as Russia and Ukraine there are unique challenges.

As Gora, et al., (2010) describe, in these countries there is decreased, rather than increased life expectancy, particularly

among males, and workers exit the labor force sooner than in other countries. There is also much economic activity that is conducted in the “shadow economy” (p. 4), thus, reducing the contributions to the system that would result from a fully functioning and open financial market. Workers collect unemployment and draw from the social protection system, while also working for wages without contributing, or their employers contributing, to the social insurance programs.

Although pension reforms have been underway in both Russia and Ukraine, success of these efforts depends on a number of factors including the development of effective financial markets within countries as well as access to international financial markets with which to be able to develop pension fund portfolios (Holzmann, 2009a). As Holzmann describes, pension systems require a combination of five components. These include a noncontributory component such as from social pensions or social assistance programs which are designed to provide a minimum level of income protection. In addition to the noncontributory component there should be contributory components. One contributory component should be linked to earnings; another component should be in the form of individual savings accounts; a fourth component should consist of voluntary contributions; and, a fifth component should consist of intergenerational financial and nonfinancial sources of support for the elderly such as access to health care and housing (Holzmann, 2009a, p. 10).

In both countries, reform efforts have not yet been realized and “pension systems in both countries have remained basically unchanged since the Soviet era” (Gora, et

al., 2010, p. 5). Continuing challenges to the pension system cited by Gora and colleagues include the extremely high rate of budget financing, paternalism, dissociation between benefits and employment, and between benefits and contributions to the pension system. Paternalism refers to the over-reliance on the single centralized government to provide all benefits to pensioners and excluding workers from directly contributing to their own pension portfolios. In addition, they describe that the actual pension age is substantially lower than the official ages of 55 for women and 60 for men. There are those, however, who continue to work beyond retirement age. Many do so because of the difficulties associated with maintaining current living situations on a pension income.

How do the Pension Systems Compare?

Russia and the Ukraine have pension systems that, much like the United States social security system, place pensioners into three different categories, each with its own regulations and payment amounts (SSA, 2010). The three types of pensions are old-age pensions, disability pensions, and survivor pensions. The amount paid to a member of each category varies by country, as does the method by which the amount is calculated.

In Russia, a standard pension is paid to citizens who are employed or self-employed; as well as to independent farmers. Those who are self-employed receive 10,392 rubles (RUB) or \$343 per month, compared to those who are employed who will receive 26% of their salary as pension, with a maximum salary limit of RUB415,000 (\$13,692) per year. In Ukraine, self-employed receive 3.2% of the minimum

monthly wage (884 hryvnias UAH), or UAH93 (\$36) per month; and, those who are employed receive 33.2% of their salary, with a maximum salary limit of UAH13,660 per month (\$1,701). In comparison, in the United States social security benefits are based to the worker's average monthly earnings, adjusted for inflation. The maximum monthly pension in 2011 was \$2,366.

Old-Age Pensions

The basic type of pension in all three countries is an old-age pension, paid to eligible individuals once they reach retirement age. In both Russia and Ukraine, the age of retirement is 60 years for men and 55 years for women, compared to the United States, which is 62 years for both men and women. Eligibility based on work experience differs by country. In Russia, one must have worked for a minimum of five years to qualify for an old-age pension. In Ukraine, the minimum employment requirement for an old-age pension is 25 years for men and 20 years for women. In the United States, to qualify for social security benefits one must have worked at least 40 quarters of coverage³ (120 months) in a position in which one contributed toward the social security insurance program.

Disability Pensions

In addition to old-age pensions, pensioners in all three systems may also be eligible for disability pensions. In both Russia and Ukraine, severity of disability, and thus amount of disability pension, is based on three disability groupings. Disability group 1 includes anyone who has lost 100% of their ability to work and requires constant

attendance. Group 2 disability includes anyone who has lost 100% of their ability to work, but does not require constant attendance. Group 3 disability includes anyone who had lost 50% of their ability to work and does not require constant attendance.

Some suggest that the attainment of disability pensions, particularly those based on Group 2 disability, may be based less on actual levels of disability and more on political connections or ability to navigate the bureaucracy. Merkuryeva (2004) demonstrated that there are many with the same degree of health-related disabilities who do not have an official disability status. Further, given equal degree of disability, those with higher levels of education were more likely to have an official disability status than those with lower levels of educational attainment. In a recent study of transitions in disability status, Becker and Merkuryeva (2012) provide evidence that increases in the prevalence of disability status is due not only to demographics but also to the poor economic conditions. That increases in disability status have more to do with the use of the disability pension as a means to ease economic hardship than to actual increases in disabilities among the Russian population is evidenced by the increases in Group 2 disabilities, which they describe is “a benchmark group for getting privileges and compensations (falsifying Group I status is more difficult, while Group III status invites careful, regular review)” (p. 78).⁴

Survivor Pensions

Survivor pensions, paid to spouses or in some cases other family members of

deceased pensioners, are offered in all three countries. In Russia, these pensions are paid regardless of how long the deceased was employed or at what coverage. Survivor pensions are paid to widows over the age of 55 and widowers over the age of 60; unemployed individuals who are caring for children under the age of 14 or disabled; children younger than 18 (23 if student); grandfathers older than 61; and grandmothers older than 56 years of age. In Ukraine, survivor pensions are only paid if the deceased had been covered for 25 years for men and 20 years for women. The survivor pensions are paid to spouses and parents of pensionable age or disabled, children younger than 18 (23 if student or orphan), and to parents, siblings, or grandparents (if they are not employed and care for the deceased’s dependent child younger than age eight). In addition, in the Ukraine, supplemental survivor pensions are paid if the survivor pension is less than 100% (for one survivor), 120% (for two survivors), or 150% (for three survivors) of the minimum subsistence level for a person with disabilities. In the United States, a survivor pension is considered to be the deceased’s old-age benefit/disability benefit and not a separate monetary amount. Survivor pensions may be paid to any number of the deceased’s relatives, including spouses, parents, children, and grandparents. Unlike Russia and Ukraine where survivor pensions depend on how long the deceased worked or under what conditions, in the United States pensions are a redistribution of already earned benefits, and not additional funds. If a deceased individual is entitled to old-age benefits, survivor pension regulations stipulate which family members may receive those benefits.

Summary/Challenges

The key issue, regardless of the similarities and differences in the structure of the pensions systems, is how effective the social protection system is in each country in meeting the needs of its aging population. The primary challenges to their effectiveness are just as much determined by the demographics of the population as they are

by the economic conditions and policies within the country. In the following sections we review the demographic and economic conditions and policies that affect the pension systems. These analyses are then followed by an examination of the specific conditions of the elderly who receive services at Hesed centers in the FSU and a comparison of the services they receive with those of similar elderly in the United States.

Status of Elderly Population in Russia and Ukraine

Macro-Indicators

Several indicators reflect the underlying conditions of a country's economy that affects its ability to meet the needs of an aging population, especially through its pension systems and its ability to implement pension reforms where needed. These include economic indicators such as GDP and inflation, as well as demographic trends such as population growth and life expectancy (see Gora, et al., 2010 for review).

Economic Indicators

Gross Domestic Product (GDP) provides an overall measure of economic activity, productivity, and growth within a country. The United States by far is the largest economy, with GDP of nearly \$12 trillion in 2010 (see Table 1). GDP per capita provides a measure of overall economic well-being. Standardizing GDP to common international currency units adjusting for purchasing power⁵ provides a metric for comparing

countries by taking into account the different price-levels across countries.

- Real GDP (adjusted for PPP) for the United States and Israel each exceeds GDP in Russia and Ukraine. *U.S. GDP (\$47k) is nearly 2.5 times larger than Russia (\$20k) and seven times larger than Ukraine (\$7k).*

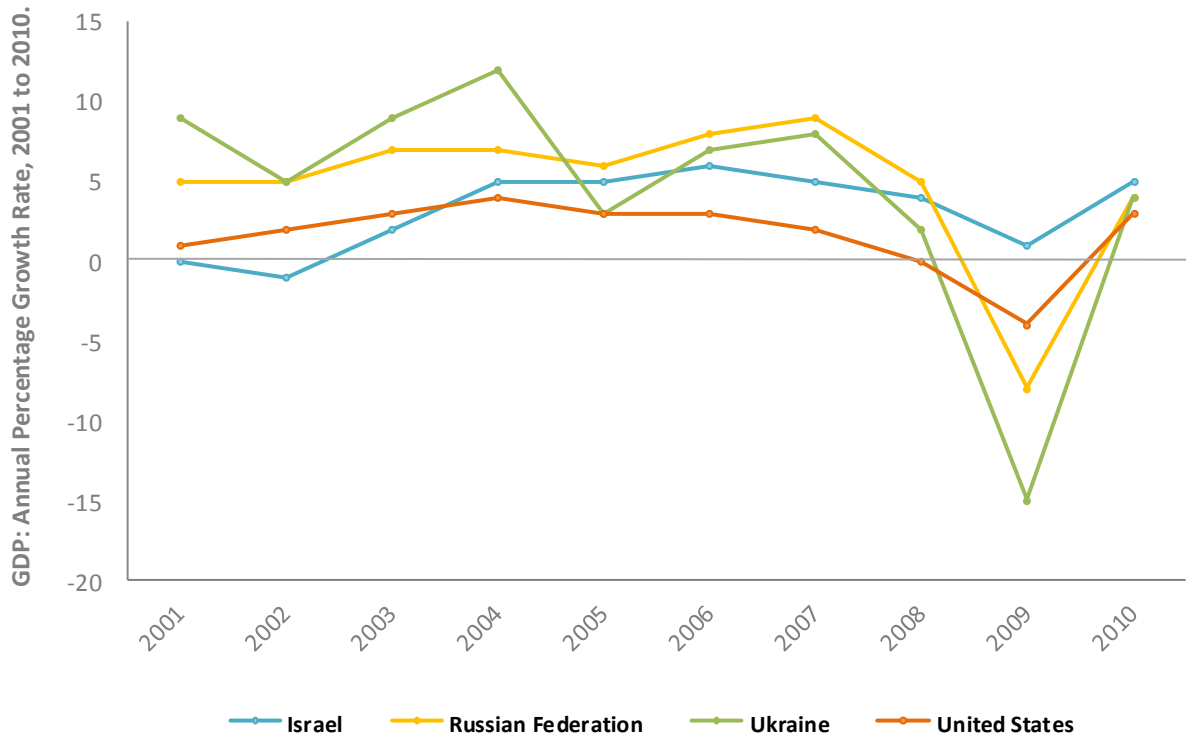
GDP post-2008. The economic crisis of 2008 disproportionately affected Russia and Ukraine compared to the United States and Israel (see Figure 1).

- GDP in Ukraine declined by 15%, Russia by 8%, compared to 4% in the U.S., while Israel saw slow growth of 1%.
- Considering the overall economic well-being of Russia and Ukraine was far below the United States to start, these declines had dramatic effects.

Table 1: Economic Indicators: 2010

	GDP (constant 2000 U.S.\$)	GDP per capita (constant 2000 U.S.\$)	Real GDP per capita, PPP (current international \$)
Russian Federation	\$ 414.4 billion	\$2,923	\$19,840
Ukraine	\$ 47.6 billion	\$1,037	\$6,721
Israel	\$ 169.8 billion	\$22,274	\$28,546
United States	\$ 11,597.9 billion	\$37,527	\$47,199

Source: World Development Indicators (WDI) and Global Development Finance (GDF) on World Bank World dataBank.

Figure 1: GDP: Annual Percentage Growth Rate, 2001 to 2010.

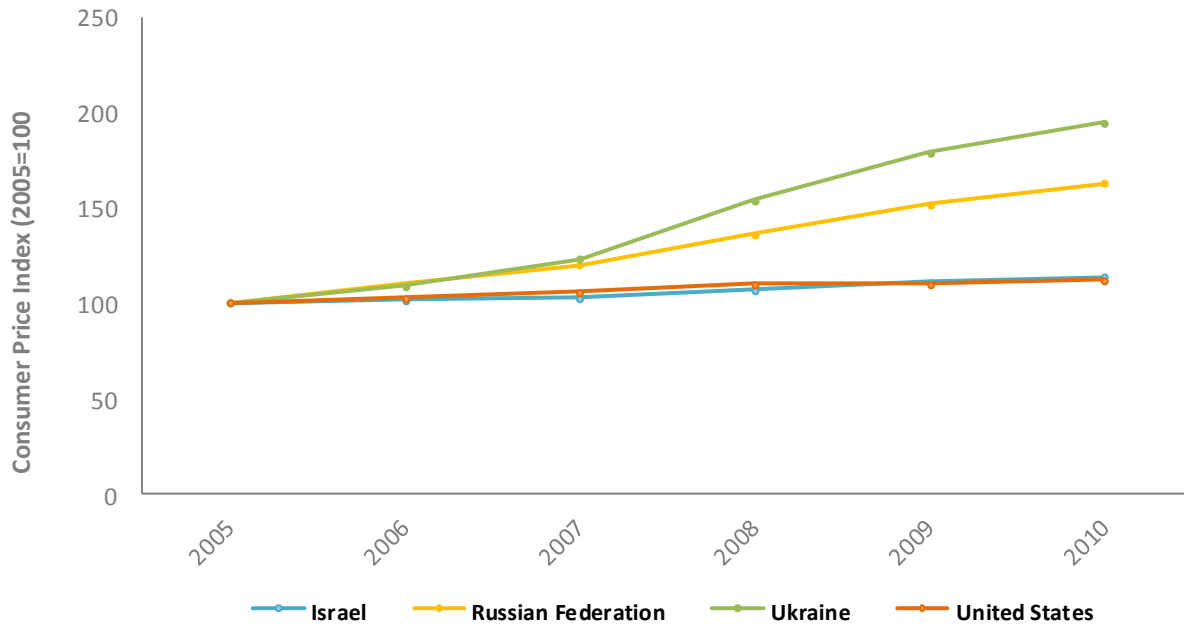
Source: World Development Indicators (WDI) and Global Development Finance (GDF) on World Bank World databank (2012).

Consumer Price Index. Figure 2 displays changes in the Consumer Price Index (CPI), which represents changes in the cost to the average consumer of acquiring a basket of goods and services within each country.

- Costs have escalated at much faster rates in Russia and Ukraine since 2008 compared to costs in the United States and Israel, which have steadily increased but at much slower rates (see Figure 2). In 2008, consumer costs in Ukraine had increased by more than 50% since 2005 (from CPI=100 in 2005 to CPI=154 in 2008), and had nearly doubled by 2010 (CPI=195). In Russia consumer costs

increased by 36% between 2005 and 2008 (CPI=136) and were 63% higher in 2010 (CPI=163). In comparison, consumer costs in the United States increased by just 10% between 2005 and 2008 (CPI=110) and increased 12% between 2005 and 2010 (CPI=112).

The increased costs represent increased burden on consumers for basic needs such as food, shelter, and energy. Such price fluctuations are especially difficult to manage on pension incomes, which to the extent they are based on government accounts of costs of living, are based to estimates of costs during the previous year.

Figure 2: Consumer Price Index, 2005 to 2010.

Source: World Development Indicators (WDI) and Global Development Finance (GDF) on World Bank World databank (2012).

Population Indicators

The age distribution of a population has several implications for understanding the economic and social conditions for the elderly. An older population increases the costs to pension systems, which places greater demands on—and requires increased contributions from—the working population to compensate. An aging population also increases demands on health care. These effects are typically seen when the proportion of those aged 65 years and older exceeds eight to 10 percent (Gavrilova and Gavrilov, 2009; Kinsella and Velkoff, 2001).

- The United States has the largest percentage of its total population that is elderly: nearly 17% are 65 years and older in the United States compared to

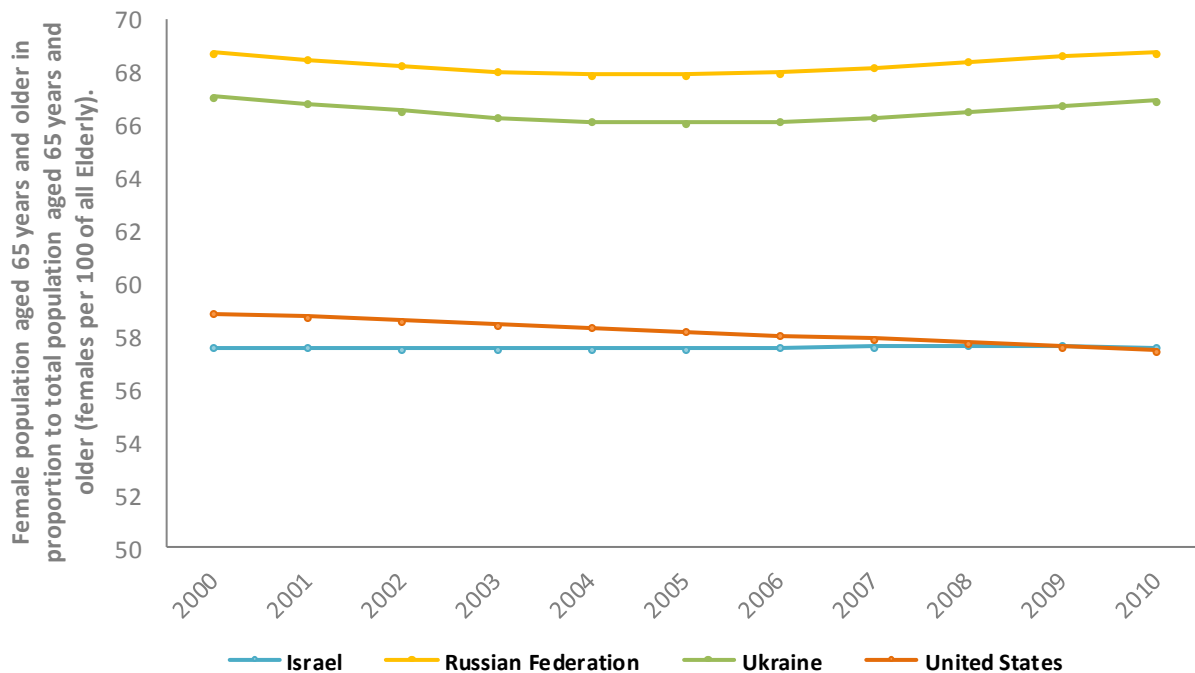
13% in Russia and 16% in Ukraine (see Table 2).

- A much greater proportion of the elderly population in Russia and Ukraine are women compared to the United States and Israel. Over two thirds of the elderly population is women (69% in Russia and 67% in Ukraine). Elderly women outnumber men by a factor of over 2 to 1, compared to a factor of fewer than 1.5 to 1 in Israel and the United States. Higher ratios of older women to older men suggest that fewer older people have spouses, and, by extension, that more are living alone. This has implications for psychological well-being as well as for needs for supportive services, since one-person households tend to be poorer. The disparity in proportions of women to men has been a long-term trend (see Figure 3).

Table 2: Total Population, Percent Aged 65 years and Older, and Proportion Female: 2010

	Population	Percent 65+	Percent women	Percent women 65+	Women 65+ per 100 men age 65+
Russia	141,750,000	12.8%	53.7%	68.7%	219
Ukraine	45,870,700	15.5%	53.9%	66.9%	202
Israel	7,624,600	10.4%	50.7%	57.5%	135
United States	309,050,816	16.8%	50.7%	57.4%	134

Source: World Bank, World Development Indicators (WDI) & Global Development Finance (GDF) database.

Figure 3: Female Population Aged 65 years and Older in Proportion to Total Population Aged 65 years and Older (Females per 100 of all Elderly).

Source: World Development Indicators (WDI) and Global Development Finance (GDF) on World Bank World databank (2012).

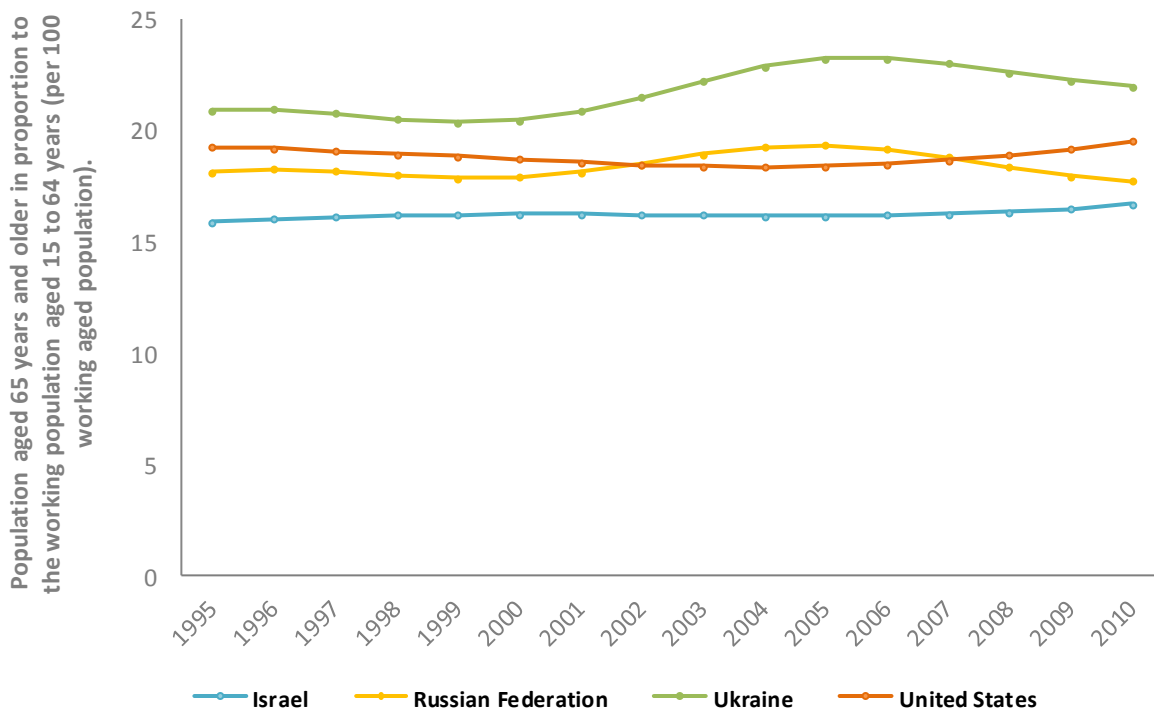
Aged dependency ratios. Figure 4 displays the aged dependency ratios represented as the number of elderly per 100 of the working aged population (i.e., aged 15 to 64 years). The proportion of elderly relative to those of working age represents the burden of the elderly on the working population.

- Ukraine has the highest dependency ratio, with 22 people aged 65+ for every one hundred 15 to 64-year-olds.
- The trend in Ukraine has remained

consistently higher than in all other regions.

- Trends in Russia mirror those in Ukraine, though rates are more comparable to those observed in the United States.
- Israel maintains the lowest proportion of elderly relative to the working age population of the four countries.

Figure 4: Population Aged 65 years and Older Relative per 100 Working Aged Population 15 to 64 years.



Source: World Development Indicators (WDI) and Global Development Finance (GDF) on World Bank World databank (2012).

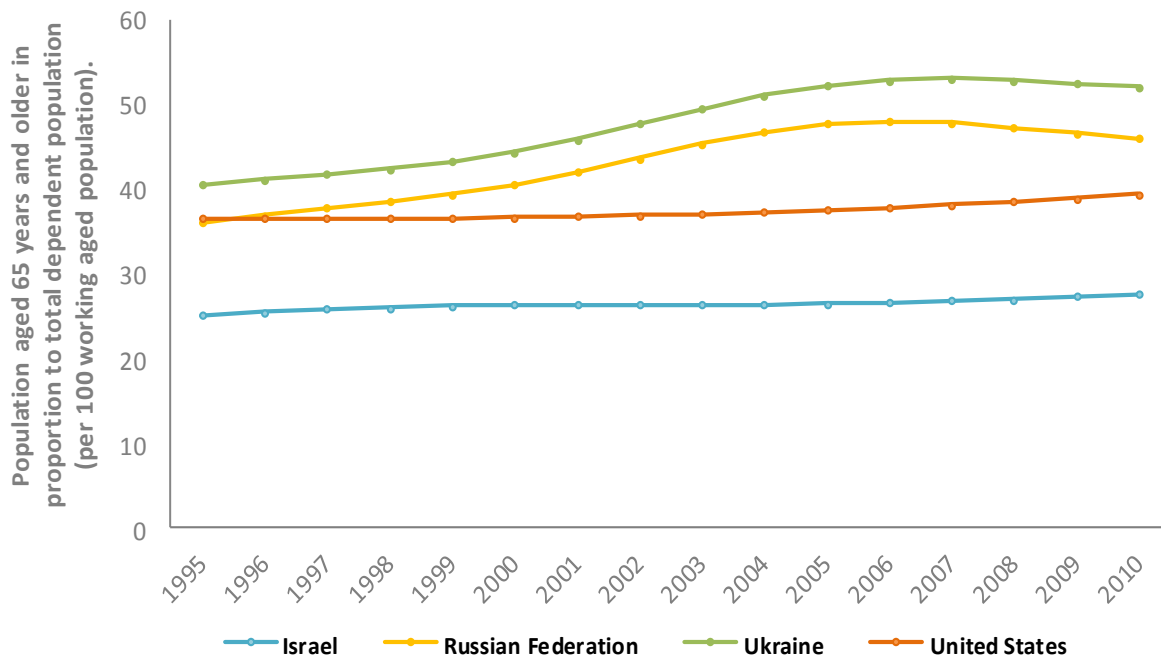
Elderly as proportion of total dependent population. The distribution of the elderly population relative to the total dependent population, that is, those aged 0 to 14 years as well as those over 65 years, is displayed in Figure 5. This indicator provides information on the composition of the dependent population, elderly relative to children. Both dependent populations place burdens on social protection systems. When the percentage of the elderly within the dependent population increases, greater burdens are placed on pension and other social systems for the elderly relative to the social protection system for children.

- The proportion of all dependents who are elderly has steadily increased

throughout the past decade in Ukraine and Russia, indicating the increasing demands on the social protection systems for the elderly.

- Since 2004, the majority of the dependent population in Ukraine have been elderly (over 50%).
- Russia, which had seen similar rates as those observed in the United States (below 40%) reached a high of 48% in 2006 and has remained above 45%.
- The rates have remained fairly stable over the past decade in Israel and the United States with rates between 24 to 27 elderly for every 100 dependents in Israel and between 36 to 39 elderly per 100 dependents in the United States.

Figure 5: Population Aged 65 years and Older in Proportion to Total Dependent Population (Per 100 Aged 14 years and Under and 65 years and Over).



Source: World Development Indicators (WDI) and Global Development Finance (GDF) on World Bank World databank (2012).

Table 3: Life Expectancy, 2009

	Life Expectancy Total	Life Expectancy Males	Life Expectancy Females
Russian Federation	68	62	74
Ukraine	68	62	74
Israel	82	80	83
United States	79	76	81

Source: World Health Organization, *Country Health Profiles*

Life Expectancy and Mortality

Aging populations, particularly the proportion of older women relative to men, is in large part a function of the disparity in mortality rates between countries and between men and women within countries.

- Average life expectancy in Russia and Ukraine is 68 years—more than 10 years fewer than in Israel and the United States (see Table 3).
- Women live a greater number of years, on average, than men across all countries. The difference between men and women, however, is far greater in Russia and Ukraine where women live on average 12 years longer than their male counterparts.

- Differences between countries are dramatic, particularly for males with men in Israel and the United States living 18 and 14 more years than their male counterparts in Russia and Ukraine.
- Differences in life expectancy for women are also substantial with women in Israel living on average nine years longer than female counterparts in Russia and Ukraine.

Life Expectancy at Age 60

For those who have survived into their older years, the average expected number of years beyond 60 has steadily increased in Israel and the United States (see Table 4).

Table 4: Life Expectancy at Age 60, Males and Females, 1990, 2000 & 2009

	Male			Female		
	1990	2000	2009	1990	2000	2009
Russian Federation	14.7	13.2	14.0	19.6	18.7	20.0
Ukraine	15.4	14.1	14.6	19.6	18.9	19.6
United States	18.5	19.8	21.5	22.9	23.2	24.5
Israel	19.3	20.7	22.8	21.6	23.1	25.5

Source: World Health Organization, *Global Health Observatory Data Repository, Life Tables (2012)*.

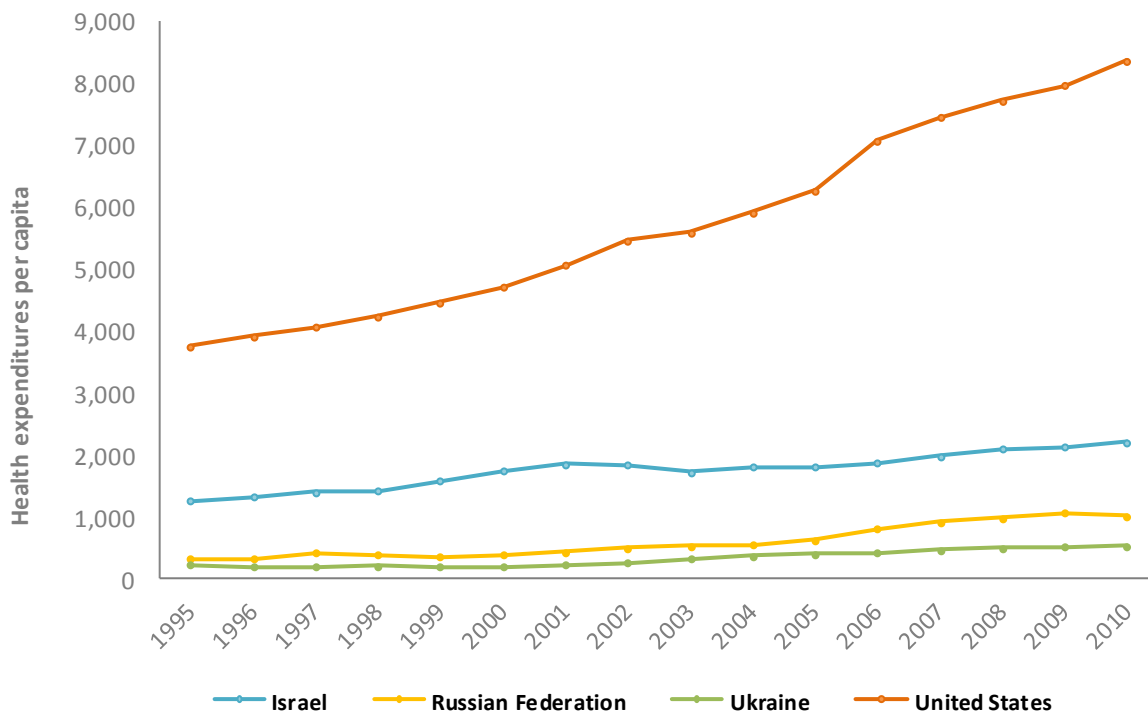
- Life expectancy at age 60 for men in Russia (14 years) and Ukraine (15 years) is seven to eight years lower than in the United States (22 years) and Israel (23 years), compared to four to five years for women.
- Although life expectancy at age 60 has increased for both men and women since 1990 in the United States and Israel, such benefits to overall life expectancy have not been experienced by those in Russia and Ukraine. Life expectancy at 60 declined between 1990 and 2000 and have not increased from the rates of 1990.

Health System

Healthy aging depends on the healthcare infrastructure, including expenditures, workforce and facilities, availability of essential medicines, vaccines, prevention of infectious diseases, and availability of long-term care, including home care.

As with other economic indicators, total health expenditures per capita in the United States far exceed those in Russia and Ukraine, and in Israel as well (see Figure 6). These include all public and private expenditures in the provision of health

Figure 6: Health Expenditures Per Capita, 1995 to 2010.



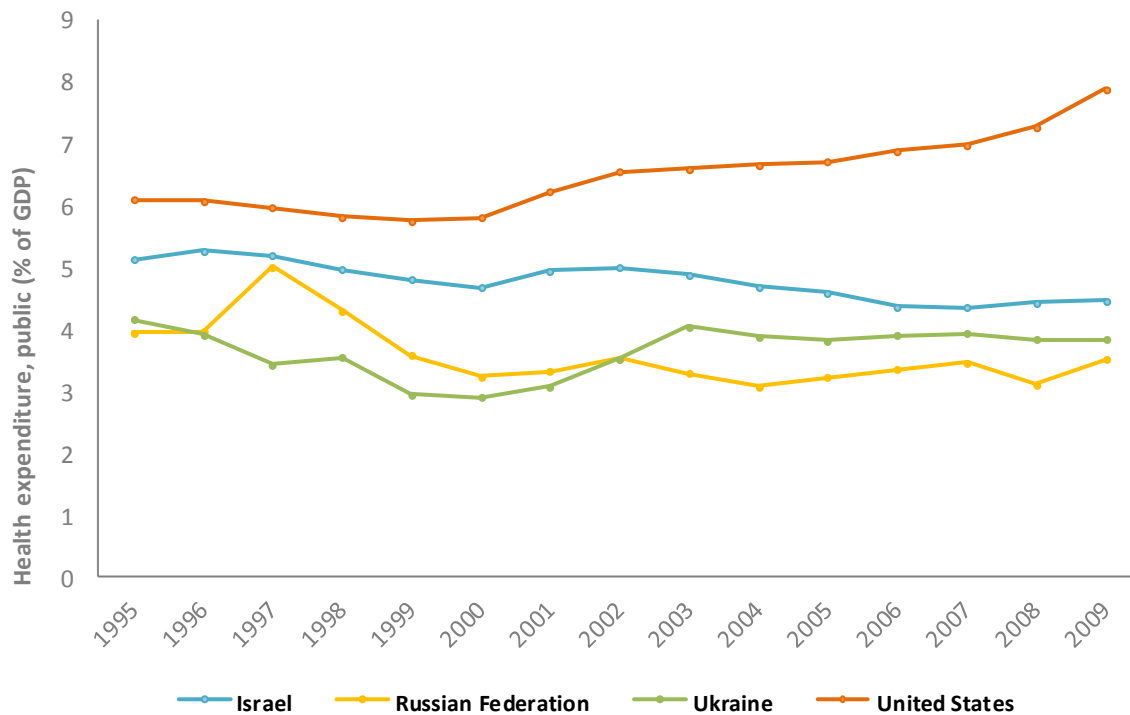
Source: World Development Indicators (WDI) and Global Development Finance (GDF) on World Bank World databank (2012).

services, family planning activities, nutrition activities and emergency aid. In 2010, expenditures in the United States were \$8,400 per capita compared to \$500 in Ukraine and \$1,000 in Russia.

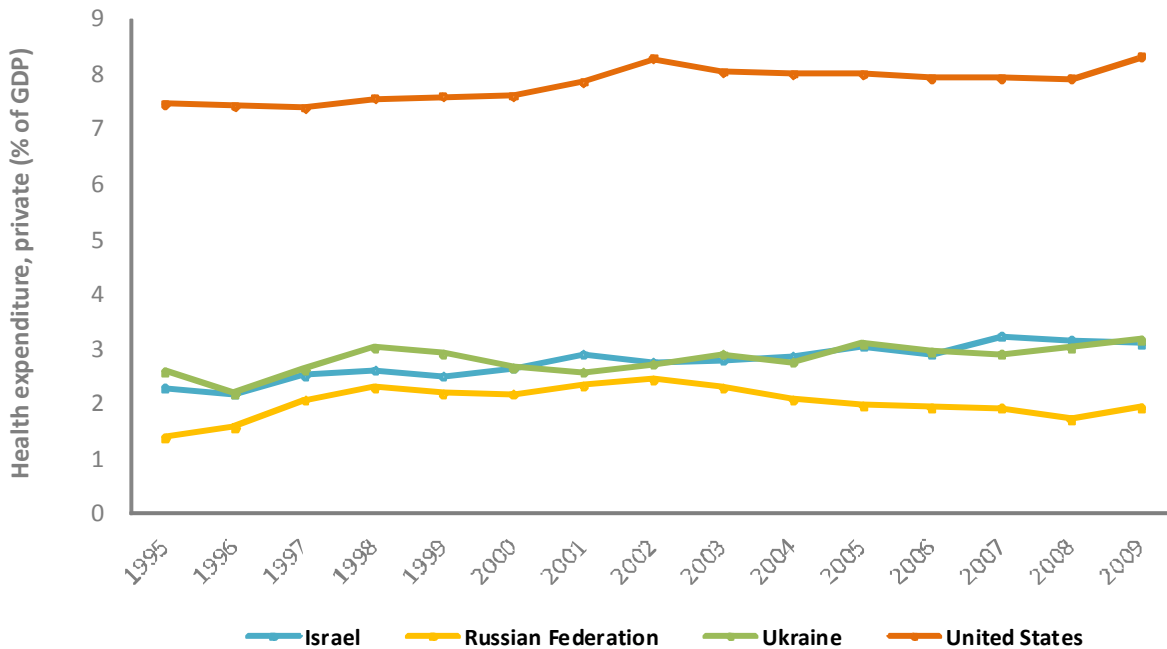
Public expenditures as percent of GDP indicates the total government spending on health, including social health insurance programs (see Figure 7a). In Russia and

Ukraine, this number has hovered around and below 4% of GDP for well over the past decade, throughout the period of transition. In contrast, in the United States, public health expenditures are nearly 8% of GDP. Further, in the United States, private expenditures are nearly equal to or exceed public expenditures (see Figure 7b). In Russia and Ukraine, private expenditures tend to be lower than public expenditures,

Figure 7a: Public Health Expenditures as Percent of GDP, 1995 to 2009.



Source: World Development Indicators (WDI) and Global Development Finance (GDF) on World Bank World databank (2012).

Figure 7b: Private Health Expenditures as Percent of GDP, 1995 to 2009.

Source: World Development Indicators (WDI) and Global Development Finance (GDF) on World Bank World databank.

indicating that there are fewer private resources available to supplement the lower percentage of public resources.

A lack of public and private insurance coverage results in increased burdens on household incomes to cover health care costs independently. Estimates of out-of-pocket payments for health expenditures as a percentage of total health expenditures provide a measure of the effectiveness of health insurance systems in a country (see Figure 8).

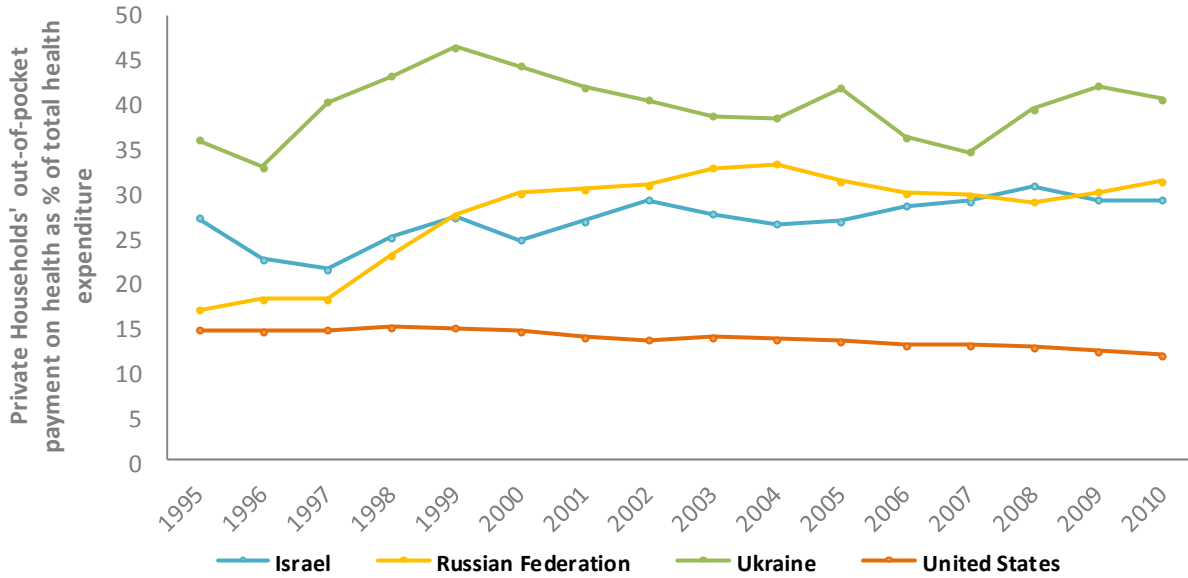
- *Out-of-pocket expenditures are more than three times greater in Ukraine than in the United States.* Over 40% of health care costs must be paid out-of-pocket in Ukraine compared to approximately 13% in the United States.

- Rates of out-of-pocket expenditures are similar in Russia and Israel, each around 30%.

The number of nursing and elderly home beds provides a basic indicator of the healthcare infrastructure available to support long-term care needs of an aging population (see Figure 9).

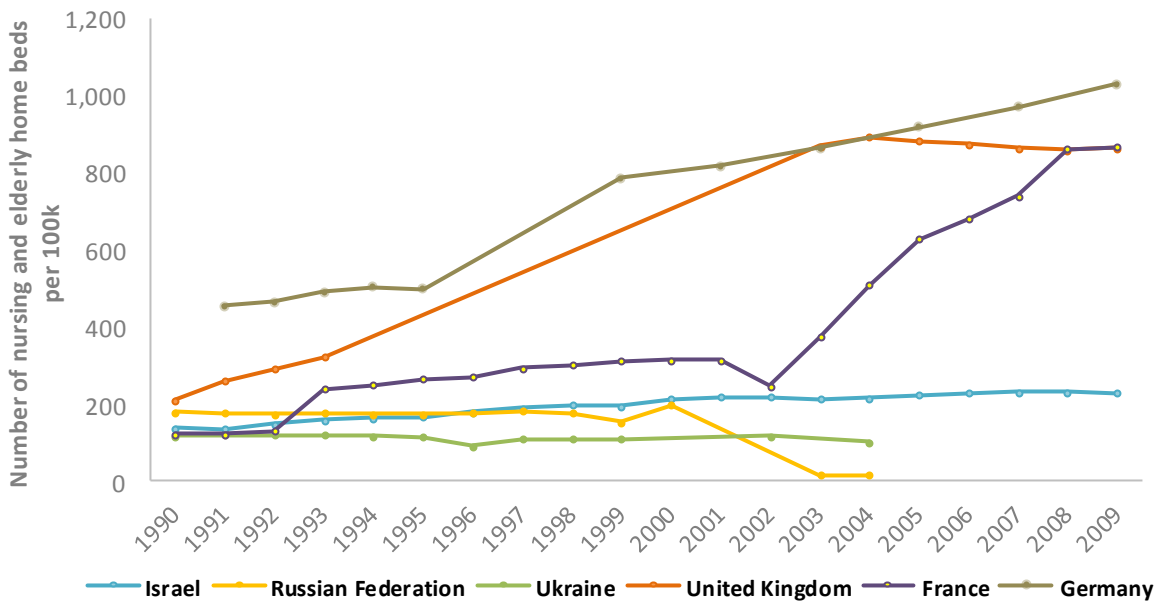
- Throughout the past two decades, rates of nursing home beds have increased in Israel and increased dramatically in European countries such as the UK and France, whereas rates declined in both Russia and Ukraine, from a high of nearly 200 beds per 100,000 in 1990 to near 0 in 2004 in Russia, at which point both countries stopped reporting.

Figure 8: Private Households' Out-of-Pocket Payment on Health as Percent of Total Health Expenditure: 1995 to 2010.



Source: World Development Indicators (WDI) and Global Development Finance (GDF) on World Bank World databank (2012).

Figure 9: Nursing and Elderly Home Beds Per 100,000 People: 1990 to 2010.⁶



Source: WHO/Europe, European HFA Database (2012).

Summary

The population, economic, and health indicators highlight some of the challenges inherent in the larger social context of Jewish elderly who reside in the FSU compared to those in countries such as the United States and Israel. The evidence makes clear that FSU countries are much poorer, and, as such, much less able to fully fund social safety nets—pensions and healthcare—required for healthy aging. The FSU countries are comprised of older populations where the number of women greatly exceeds the number of men, an indication of both economic risk (with female-headed households more likely to be dependent on one income) and social isolation (with many females living alone). The increasing number of elderly in the FSU relative to both the working population and the total dependent population over the past

two decades, with increasing rates during this past decade of additional economic crises, contrasts with the relative constant ratios over the same time periods in Israel and the United States. This disparity in the aging population relative to the working population and children highlights the challenges to the pension systems in these countries and their ability to fund these programs. Per capita health care expenditures in the FSU are only a fraction of expenditures in the United States and Israel and are indicative of the lower level of resources available to treat the health care needs of the elderly. This reality is also reflected in the high proportion of out-of-pocket payments for health expenditures in the FSU, particularly in Ukraine. Life expectancy, which can be considered a proxy for living conditions as well as the effectiveness of health care systems, is substantially lower in the FSU countries.

Condition of Elderly within Regions

To assess the situation of the elderly Jewish population of the FSU and how it compares to their counterparts in the United States, we first describe the elderly within each region.

Former Soviet Union

There is no single, independent data source that explicitly describes the elderly Jewish population in Russia and Ukraine, particularly their health and social conditions. The only systematic source of data that exists is for the subset of elderly who are served by Hased centers, a result of the extensive intake and case management data that is collected for those who receive services. As a resource for describing the needs of elderly served by these centers, the Hased data are unparalleled. With these data we can describe the conditions of Jewish elderly “who are known” to Jewish service agencies. This may not be a representative sample of all elderly and the needs of all elderly. These data can, however, be used, at the minimum, to describe the conditions and needs of elderly who are known to be in need.

Demographics

The overall number of elderly clients who received services in the past year declined by nearly 40% since 2004 (see Table 5).⁷ In Russia, there were over 90,000 elderly clients served in 2004 compared to 57,000 in 2011. This reduced number of clients reflects, in large part, the diminishing numbers of Nazi victims. The number of Jewish elderly Nazi victims who received services in Russia dropped to 38,669 in 2011 from 57,933 in 2006. This corresponds to a reduction of over 19,000, or, on average, approximately 55 Nazi victims per 1,000 per year. This is consistent with estimated mortality rates among Nazi victims (Be’er, 2011). The reduction in Ukraine averaged 48 Nazi victims per 1,000. Among non-victims (NNV), the number of clients in Russia also decreased by 40%—from 31,265 in 2006 to 18,413 in 2011. Unlike the NV population, the NNV population is non-finite. The decreased number of clients reflects the reduction in resources available to provide services.⁸

Table 5: Number of Elderly Clients: 2004, 2006, 2011

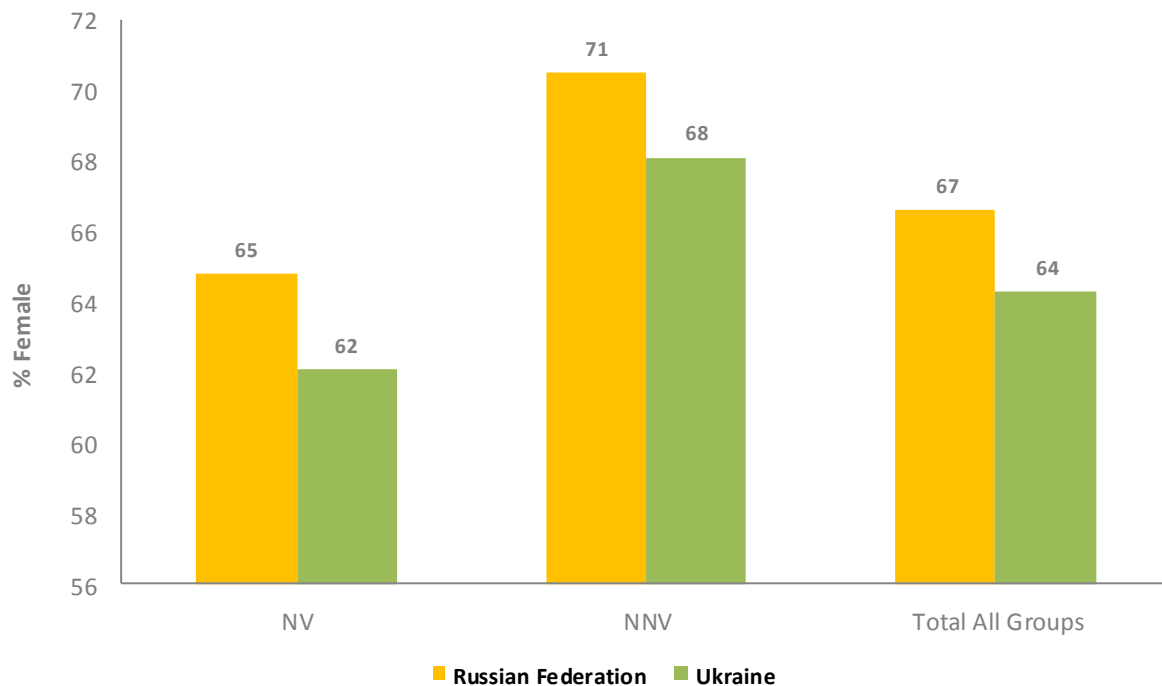
		2004	2006	2011
Russia	Total	97,278	89,198	57,082
	NNV	40,411	31,265	18,413
	NV	56,867	57,933	38,669
Ukraine	Total	60,404	55,521	44,536
	NNV	17,369	16,100	16,374
	NV	43,035	39,421	28,162

Proportion female. Similar to national level distributions of elderly, elderly NNV (and NV) clients are predominantly women (see Figure 10).

- There is a greater proportion of women relative to men in both Russia and Ukraine.

- The proportion of women to men is greater among NNV clients than NV clients in both Russia and Ukraine. *Over 70% of NNV clients in Russia and 68% in Ukraine are women.*

Figure 10: Percentage of Elderly Clients in Russia and Ukraine, Aged 65 years and Older Who are Female, 2011.



Age Distribution. Elderly NNV clients are, on average, 74-years-old in Russia and 73-years-old in Ukraine. A majority of NNV clients in each country are in the lower age range of 65 to 74 years (Table 6).

- The majority of NV clients in Russia are in the middle age range of 75 to 84.
- The proportion in the higher age range (85+) is greater among NV in both countries for both men and women, reflecting the aging of the NV population.

Economic and Social Conditions

Pensions. Median monthly pension incomes ranged from around UAH1,000 in Ukraine to RUB9,000-10,000 in Russia (see Table 7).

- Expressed in U.S. dollars, the median monthly pensions for NNV clients is \$125 per month in Ukraine and \$294 per month in Russia. When local currency is standardized to current international dollars, pensions in Russia are \$421 monthly compared to \$256 in Ukraine.

Table 6: Percent by Age Group

		65-74	75-84	85+
Russia	Total all groups	44.9	40.5	14.6
	Men	45.0	43.8	11.8
	Women	44.9	39.0	16.1
	Total all NNV	59.2	29.7	11.1
	Men	59.3	29.8	10.9
	Women	59.2	29.6	11.2
	Total all NV	38.1	45.6	16.2
	Men	39.3	49.0	11.7
	Women	37.5	43.8	18.7
Ukraine	Total all groups	52.7	35.3	12.0
	Men	54.7	36.1	9.2
	Women	51.6	34.8	13.6
	Total all NNV	68.5	23.6	7.9
	Men	72.5	22.8	4.7
	Women	66.6	24.0	9.4
	Total all NV	43.6	42.0	14.4
	Men	46.0	42.6	11.4
	Women	42.1	41.6	16.2

**Table 7: Median Monthly Pension Income:
Elderly Hased Clients: 2011**

		Local currency	U.S. dollar ^a	PPP adjusted ^b
Russia	NNV	9,477	294	421
	NV	10,300	319	457
Ukraine	NNV	1,013	125	256
	NV	1,129	139	285

Notes: a) The equivalent to U.S. dollar pension was calculated using the average exchange rates for 2011 (source: <http://www.oanda.com/currency/historical-rates/>) b) The PPP adjusted numbers were calculated based on 2011 Implied PPP conversion rates obtained on the International Monetary website.

- Within each country, pension incomes are lower among NNV clients compared to NV clients.

Living Situation. The living situation of Hased clients is categorized into those living alone with family nearby and without family nearby, those living as a couple (with spouse), also with family nearby or without family nearby, and those living with family (see Table 8).

- Over a third of elderly Hased clients live alone: 38% of NNV clients in Russia and 35% of NNV clients in Ukraine live alone.

- *Nearly 18% of NNV clients in Russia and 16% in Ukraine live alone with no family nearby*
- Rates of living alone are higher among Nazi-victims than non-victims.

Health Status

The health status of Hased clients is determined by assessment on intake. Should this assessment identify vision, hearing or mobility problems, clients are referred for follow-up diagnostics to determine if there is need for home care service. Thirty-six percent of all Hased clients in 2011 were

Table 8: Living Situation: 2011

		Lives Alone			Lives w/ spouse			Lives w/ Family
		All	no family nearby	family nearby	All	no family nearby	family nearby	
Russia	NNV	37.9	17.7	20.2	44.2	15.6	28.6	17.9
	NV	46.4	23.9	22.5	38.4	14.6	23.8	15.1
Ukraine	NNV	35.2	16.4	18.8	51.7	20.7	31.0	13.1
	NV	48.4	25.0	23.4	39.2	15.5	23.7	12.4

referred for such follow-up diagnostics (see Table 9).

- Overall, rates of impaired vision, hearing, and mobility were higher among NV than NNV clients.
- Of the NNV clients, there were higher rates of vision problems in Ukraine than in Russia, with 16% of NNV clients having impaired vision or blindness in Ukraine compared to 12% of NNV clients in Russia.

Activities of daily life. A key measure in the evaluation of the quality of life and daily functioning of elders is the Activities of Daily Life (ADL) scale (cf., Spitzer, 1987). This scale measures the ability of the elder to perform daily tasks ranging from personal care—such as bathing, dressing, continence, and eating—to personal finance, housework, and taking essential medicines. Hesed clients are assessed on 14 activities of daily life. These are:

- *Mobility outside the home*
- *House cleaning*
- *Laundry*

- *Cooking and preparing food*
- *Mobility within the home*
- *Falls during the last three months*
- *Dressing*
- *Personal hygiene*
- *Eating and drinking*
- *Taking medicines*
- *Bodily functions*
- *Supervision*
- *Eyesight*
- *Hearing*

Each activity is assessed on a multi-point scale to represent the typical range of abilities for each activity. For example, Mobility outside the home is assessed on a five-point scale: 1=Ventures outside the home without difficulty, 2=Does not leave home in the winter, 3=Ventures outside the home but cannot carry shopping bags by oneself, 4=Only leaves home when assisted, and 5=Does not leave home at all. Dressing is assessed on a three-point scale: 1=Dresses without assistance, 2=Needs minor assistance when dressing (putting on socks or shoes, doing buttons), 3=Requires significant assistance with dressing. In addition, each point on the scale is assigned

Table 9: Vision, Hearing & Mobility Problems: 2011

		Vision	Hearing	Mobility
Russia	Total	17.4	11.9	1.6
	NNV	12.3	8.4	1.2
	NV	19.8	13.5	1.8
Ukraine	Total	23.8	14.4	2.5
	NNV	16.1	8.7	1.7
	NV	28.4	17.6	3.0

a weight or score ranging from 0 to 2. For example, Mobility outside of the home, ratings of 1, ventures outside of the home without difficulty are assigned a 0. Ratings of 2 and 3 are assigned values of 0.75, values of 4 are assigned a score of 1, and values of 5 are assigned a value of 2.

The key issue is to identify those who require active human assistance and for whom homecare services are critical. Hased provides a summary measure of functioning as the sum of scores across all 14 ADLs and categorizes clients into six groups:

- *Functions independently-From:0 To:3*
- *Independent function limited by 20%-From:3.25 To:4.5*
- *Independent function limited by 40%-From:4.75 To:6*
- *Independent function limited by 60%-From:6.25 To:10.75*
- *Independent function limited by 80%-From:11 To:15.75*
- *Independent function limited by 100%-From:16 To:25*

Distribution of clients by level of functioning is displayed in Table 10, along with a summary of the ADL/IADL diagnostics. This includes the proportion of clients identified with any limitation, along with the specific activities those with any

limitation experience. For example, while 26% of NV clients in Russia have any ADL/IADL limitation, 6.8% of those have limited mobility inside the home, 14% have limited ability to dress themselves, and 35% are unable to bathe themselves without assistance.

- Overall, nearly 10% of NNV clients are limited by more than 60%.
- 26% of NNV clients in Ukraine and 16% of clients in Russia have at least one functional limitation with an ADL/IADL.
- Of NNV clients with functional limitations:
 - ◊ Nearly a third (30.2%) require assistance with personal care, such as bathing.
 - ◊ A majority (74% in Russia, 67% in Ukraine) require assistance with preparing meals.
 - ◊ 30% of NNV clients in Russia and 24% of those in Ukraine require assistance managing medicines.
 - ◊ A majority of the NNV clients with functional limitations have impaired vision (68%).
 - ◊ A large proportion of clients are hearing impaired (42%), and have limited mobility outside the home (49%).

Table 10: Functioning, Activities of Daily Life: 2011

	Russia		Ukraine		Russia and Ukraine Combined	
	NV	NNV	NV	NNV	NV	NNV
Functional						
Functions independently	76.2	85.7	65.0	82.4	71.5	84.1
Independent function limited by 20%	4.1	1.9	6.7	3.0	5.2	2.4
Independent function limited by 40%	5.9	3.3	7.5	4.6	6.5	3.9
Independent function limited by 60%	8.3	5.4	12.4	5.9	10.1	5.6
Independent function limited by 80%	3.6	2.5	6.3	3.1	4.7	2.8
Independent function limited by 100%	1.6	1.0	2.0	1.0	1.8	1.0
Specific Activities of Daily Life						
Any ADL/IADL ^a	26.4	16.1	43.1	25.7	36.7	23.1
Mobility inside the home ^b	6.8	7.3	7.0	6.7	6.9	7.0
Dressing ^b	14.1	15.2	12.1	10.7	13.0	12.6
Personal hygiene ^b	34.8	35.4	32.7	26.6	33.7	30.2
Continence ^b	10.2	11.1	9.1	7.9	9.6	9.3
Eating and drinking ^b	6.6	6.8	6.2	5.7	6.4	6.2
Managing medicines ^b	26.0	30.1	27.7	23.9	26.9	26.5
Preparing meals ^b	74.5	74.5	76.3	67.3	75.5	70.3
Laundry ^b	50.3	50.3	50.0	41.2	50.1	45.0
Other Functional Limitations						
Requires supervision ^b	3.8	4.6	1.9	1.9	2.8	3.0
Vision impairment ^b	75.3	76.3	65.9	62.7	70.2	68.3
Hearing impairment ^b	51.3	52.2	40.9	34.0	45.6	41.5
Mobility outside the home ^b	54.3	55.7	51.2	44.1	52.7	48.9
House cleaning ^b	44.9	48.3	41.3	34.6	42.9	40.2
Falls (last 3 months) ^b	21.4	21.6	26.8	22.5	24.4	22.1

Notes: a) Represents the proportion of all clients who are limited in any of the activities of daily life as diagnosed through Hased. b) Represents the proportion of clients who have any limitation among those who have the specific limitation listed.

Services Hased clients received. Services provided to elderly Hased clients consist primarily of material support, home care, social programs, and assistance accessing medical services. For this report, we summarize the following service categories:

- Home care
 - ◊ Staff/personnel: to provide care related to limitations in functioning
 - ◊ Other services: including supplies/ services; home sanitary supplies; window cleaning; and assistance with personal hygiene, laundry, etc.
- Material Support
 - ◊ Food: provision of food/bank cards, food packages, and fresh food sets
 - ◊ Medicines: monetary assistance to access essential medications
 - ◊ Winter Relief: payment of utilities/ heating, clothes, shoes, window sealing
 - ◊ SOS: one-time emergency assistance
 - ◊ Other: social insurance, transport expenses, purchases of household

items, funeral services, appliances, furniture, bedding

- Other Services, including social programs such as day center activities, warm homes, hot lunches, meals on wheels and home cooked meals, and other medical services such as loans for medical equipment, medical consultations, hearing aids, eyeglasses, hospitalization, rehabilitation services, other medical services.

Distributions of clients receiving services across these general categories are displayed in Table 11.⁹

- A greater proportion of NV clients received Home Care services than NNV clients: 27% of NV clients overall, 35% in the Ukraine, and 22% in Russia, received Home Care services.
- Nearly all of the clients (96% of NV and 93% of NNV clients) received some form of material support.

Table 11: Percentage of Clients Receiving Services in 2011^a

	Russia		Ukraine		All	
	NNV	NV	NNV	NV	NNV	NV
Home Care						
Home care hours	10.7	18.1	12.4	27.0	11.4	21.8
Any Home care	13.3	22.1	17.1	35.1	15.0	27.6
Any material support	90.4	93.9	96.4	98.9	93.1	96.0
Money card / Food card	49.9	55.9	77.7	89.1	62.7	69.8
Medicines	30.4	35.5	53.2	73.3	40.9	51.3
Winter relief	6.5	5.6	9.2	12.8	7.7	8.6
SOS	3.9	4.9	3.5	9.7	3.7	6.9
Other material support	1.4	2.8	7.2	21.7	4.1	10.7
Other services	16.5	21.2	21.8	36.5	18.9	27.6

Notes: a) Services are based to a single year of data, November 1, 2010 through October 31, 2011 and includes only those for whom services data were included in the Hased Services data extract. This results in a reduction in the number of clients included in the analysis to 96,973.

Services by Disability Level. A key issue is whether the services that are provided meet the needs of clients. For Home Care service, need can be established independently based on the IADL/ADL diagnostics and functional limitation (see Table 12). Level of disability was categorized based on ratings of functional limitations. Those with total ratings between 3.25 to 4.5 were rated as low level of disability or need; those from 4.75 to 10.75 as moderate level of disability, and greater than 10.75 as the highest level of disability (cf., Margolis, 2011).

- For 75.5% of the clients in Russia and Ukraine there is no need based on functional limitations alone. Fourteen percent have moderate need based on functional limitations and 5.7% have a high level of need based on limitations.
- Of those with the highest level of limitations, nearly all of them (92%)

received homecare services, including 85% that received home care hours.

- Material support for food was provided to a majority of clients (over 80%) regardless of level of functioning. This makes sense given that food assistance is based more on financial need and the distribution is not primarily determined by level of functional disability.

Although nearly all clients with high levels of functional limitations receive Home Care, there is variability in the amount of Home Care they receive (see Table 13).¹⁰ Two time periods are included in this table. The second portion of the table is to reflect the fact that additional funds were received specifically for provision of Home Care services to Nazi victims, and there has consequently been an increase in the number of Home Care hours for this group.

Table 12: Percentage of Clients Receiving Services by Functionality

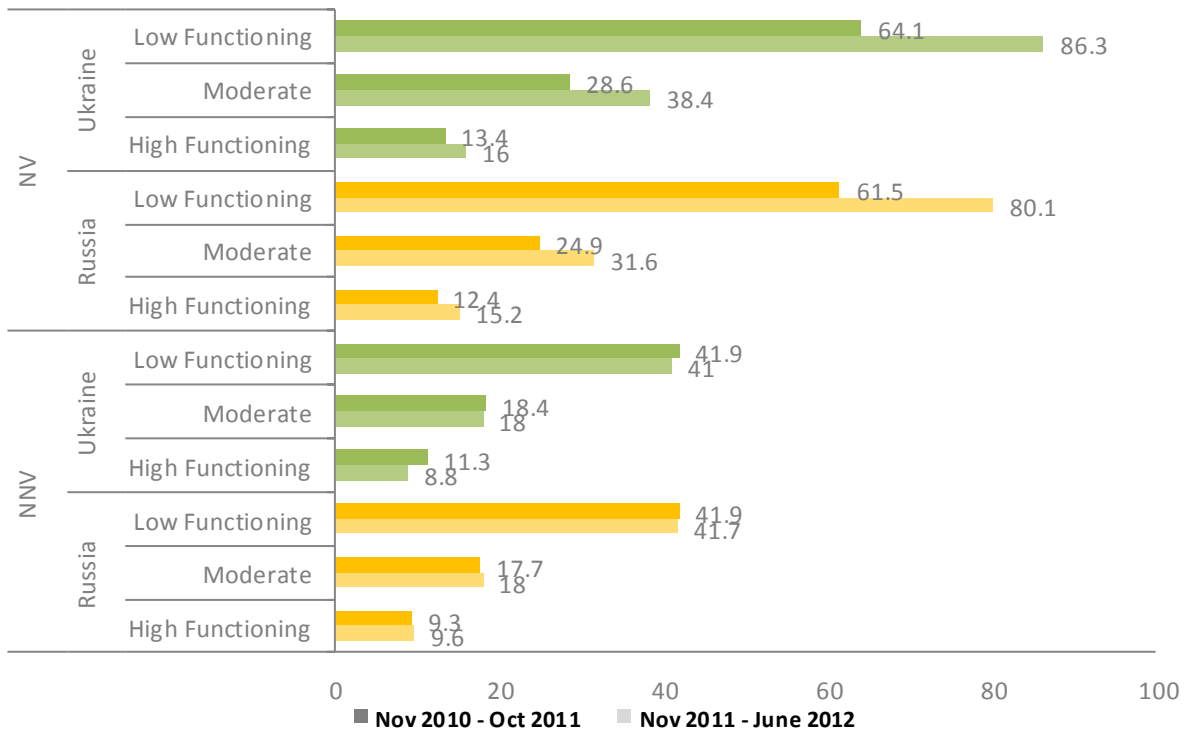
	Functional Limitations			
	None	Low	Moderate	High
Percent of all Clients w/in Level of Functional Limitation	75.5	4.2	14.5	5.7
Home Care				
Home Care Hours	--	47.2	78.9	84.9
Any Home Care	5.0	54.3	83.5	91.6
Any material support	96.6	93.3	89.7	88.7
Food	91.4	85.8	83.9	81.7
Medicines	44.2	64.3	58.1	58.1
Winter relief	7.5	13.9	10.7	9.5
SOS	4.6	8.2	9.8	10.3
Other material support	4.9	19.5	19.1	21.3
Other services	20.4	38.5	36.5	42.2

Table 13: Average Monthly Home Care Hours by Functional Limitations: Nov. 2010 – Oct. 2011 & Nov. 2011 – June 2012

	Functional Limitations	Non-Victims					Nazi Victims				
		Count	Median	Mean	SD	Max	Count	Median	Mean	SD	Max
Nov 2010-Oct 2011											
Russia & Ukraine Combined	Low Functioning	1,306	39.7	41.9	21.3	160.6	4,349	60.6	62.9	30.7	421.1
	Moderate	3,321	16.3	18.0	9.0	64.0	11,083	27.0	26.7	11.0	464.0
Russia	High Functioning	827	8.5	10.2	9.2	94.1	3,455	13.0	13.0	4.3	54.0
	Low Functioning	647	39.5	41.9	23.1	160.6	2,029	58.3	61.5	31.4	348.0
	Moderate	1,607	16.4	17.7	9.0	61.4	5,484	24.7	24.9	10.5	101.0
Ukraine	High Functioning	342	8.6	9.3	4.6	33.2	1,571	12.6	12.4	4.2	34.8
	Low Functioning	659	40.2	41.9	19.1	123.3	2,320	62.2	64.1	29.9	421.1
	Moderate	1,714	16.3	18.4	9.0	64.0	5,599	28.9	28.6	11.1	464.0
High Functioning	485	8.5	11.3	12.5	94.1	1,884	13.3	13.4	4.3	54.0	
Nov 2011-June 2012											
Russia & Ukraine Combined	Low Functioning	2,265	39.3	41.4	23.4	233.8	6,069	92.5	83.3	33.6	405.0
	Moderate	4,629	16.2	18.0	9.4	61.0	13,564	39.5	34.9	11.7	135.0
Russia	High Functioning	896	8.5	9.2	5.7	47.0	4,079	16.0	15.6	5.5	83.6
	Low Functioning	1,164	39.1	41.7	24.8	233.8	3,277	87.0	80.1	33.9	339.8
	Moderate	2,415	16.5	18.0	9.6	61.0	7,861	34.7	31.6	13.0	109.4
Ukraine	High Functioning	380	8.5	9.6	6.0	42.0	1,950	16.0	15.2	5.4	83.6
	Low Functioning	1,101	39.4	41.0	22.1	178.8	2,792	96.0	86.3	32.9	405.0
	Moderate	2,214	16.0	18.0	9.3	57.1	5,703	40.8	38.4	9.0	135.0
High Functioning	516	8.3	8.8	5.4	47.0	2,129	16.0	16.0	5.5	74.4	

- Clients most in need, that is, those identified as low functioning, typically receive a greater number of Home Care hours than those less in need.
- For the year of data from November 2010 through the end of October 2011, across both regions, NNV clients most in need of Home Care services received up to 20 fewer hours of Home Care per month than their NV counterparts. *Low functioning NNV clients typically received 40 hours of Home Care service per month compared to the 61 hours received by low functioning NV clients.*
- *With the additional funding, the average number of Home Care hours for low functioning NV clients has increased to over 80 hours per month (see Figure 11).*
- For NNV clients (bottom portion of Figure 11) there were no significant changes in the average number of Home Care hours across the two time periods, with the exception of a decrease in the number of hours received by those with higher levels of functioning. Low functioning NNV clients in both Russia and Ukraine received an average of 42 hours prior to the new funding and 41 to 42 hours since the new funding.
- In contrast, Nazi victims (top portion of Figure 11) saw an increase in the average number of Home Care hours. In Russia, low functioning NV clients averaged over 60 hours of Home Care service prior to the additional funding. With the additional funding, the average

Figure 11: Average Monthly Home Care Hours for NV and NNV clients Before and After Additional Funding: November 2010 to October 2011 Compared to November 2011 to June 2012.



number of hours for low functioning Nazi victims increased to an average of 80 hours in Russia and 86 hours in Ukraine.

Summary

The analysis of the demographic, economic, and health data from the Hased client database provided information on the conditions and needs of elderly Jews who are known to be in need. The demographic conditions and economic challenges of the FSU as highlighted in the previous section are manifested in the analysis of the data.

The proportion of female elderly clients is larger for both countries. The majority of NNV clients (59% in Russia and 68% in Ukraine) are in the 65 to 74 age group, indicating the persistent needs of the elderly Jewish population in these countries. Although the true economic status of elderly clients in the FSU is difficult to evaluate, it is clear based on the pensions that they are impoverished (see comparative analysis section below). Overall, pensions are lower in Ukraine than in Russia, and are slightly lower for NNV clients compared to Nazi victims. A third of the elderly clients live alone, subsisting with only one pension. A significant proportion of elderly clients in the FSU have functional limitations. Almost a quarter of the non-victims need help with at least one activity of daily life (ADL), and within this group a substantial number have vision and hearing impairment and are limited in their mobility.

It is clear from the analysis of the service data that almost all Hased clients (more than 90%) required and received material support regardless of functional limitation. Whether there are differences in the amount of material support needed and received by

NNV clients compared to NV clients cannot be determined with these data. The picture is clearer for services provided for those in need of Home Care. Nearly all those with the highest level of limitations received home care services. The overall number of hours of care tended to be lower for NNV clients across all levels of functional limitations. The differences between NV and NNV clients in the average number of Home Care hours received increased since August 2011 with Nazi victims receiving substantially more hours of Home Care service given equal levels of need.

United States

Several sources of data were examined to describe the social and health conditions of elderly in the United States in a way that would be most comparable to available data on Jewish elderly in the FSU. These include the most recent Jewish population surveys conducted in major metropolitan areas in the United States along with data from the Health and Retirement Survey (HRS).¹¹ HRS is the largest national social science data collection on aging in the United States (Juster & Suzman, 1995). With support from the National Institute on Aging and the Social Security Administration, it consists of a nationally representative sample of nearly 30,000 adults 50 years of age and older. Participants are interviewed every two years, beginning in 1992. This dataset enables comparison of older Jewish adults in the targeted metropolitan surveys with a representative sample of all elderly in the United States. In addition, for analysis of home care and medical expenditures, data from the Medical Expenditure Panel Survey (MEPS, Agency for Healthcare Research and Quality, 2009) were examined. The MEPS, begun in 1996, consists of a nationally representative sample of families

and individuals in the United States, along with their medical providers (including physicians, hospitals, and pharmacies) and their employers. The primary purpose of the survey is to assess the range of medical services received, the costs associated with services and the payment methods (private insurance, public expenditures, patient out-of-pocket) used.

Demographic, social, and health conditions of U.S. elderly are presented in Table 14 through 16.

Demographics

- A greater proportion of elderly in the United States are female than male (see Table 14). The estimated proportion varies

Table 14: Characteristics of Population 65 Years and Older in the United States

	HRS 2010	New Haven 2010	NJ Middlesex 2008	Chicago 2010	Baltimore 2010
<i>% Female</i>	56.3	65.2	70.3	51.4	57.6
<i>Age</i>					
Average age	74.8	77.7	76.7	75.8	76.6
65-74 years	54.2	38.2	37.0	48.6	46.0
75-84 years	33.7	36.3	47.2	35.4	33.6
85+ years	12.1	25.5	15.9	15.9	20.3
<i>Marital Status</i>					
Married	56.7	53.5	56.8	57.8	63.7
Widowed	26.0	33.9	36.7	22.8	25.1
Divorced	11.6	8.1	4.6	11	5.0
Separated	--	0.1	0.3	1.4	0.9
Single/never married	3.0	4.4	1.5	4.1	1.8
Living w/partner/cohabiting	2.8	--	0.2	2.9	3.6
<i>Income</i>					
Poverty	9.2	2.0	3.3	--	0.0
Household income					
< \$25k (< ~ \$2k monthly)	34.5	20.9	22.7	23.5	21.3
\$25k-\$50k (~ \$2k-4k monthly)	30.8	20.0	26.1	21.6	34.8
\$50k-\$100k (~ \$4k-8k monthly)	22.6	25.5	30.0	26.4	24.1
> \$100k (> ~ \$8k monthly)	12.2	33.6	21.2	28.5	19.8
Needed financial assistance in past year	--	3.6	2.4	13.6	--
Received financial assistance in past year	--	23.8	84.6	--	--

from 56% of all elderly represented in HRS 2010 to a high of 70% estimated in the New Jersey Middlesex Jewish population survey.

- Over half are married or living with a life partner. The HRS 2010 estimates 57% of U.S. elderly are married and 2.8% living with a life partner. The Jewish population survey of Baltimore estimates over two thirds of the elderly in that region are married or living with a partner.
- New Haven and New Jersey, locations with the highest proportion female relative to male, also have the highest proportion of elderly who are widowed. Thirty-four percent of elderly in New Haven and 37% in New Jersey are widowed. Clearly, the greater number of elderly women relative to men is associated with marital status, with fewer who have spouses, and subsequently fewer who have the benefits of the additional income and social support that come from having a spouse or partner.
- *Median household income for elderly in Jewish community surveys is substantially higher than median income for all U.S. elderly.* Thirty-four percent of all U.S. elderly live on income less than \$25,000 annually, compared to just 21%-24% of Jewish elderly. Twelve percent of all U.S. elderly have incomes greater than \$100,000 annually, compared to 20% to 34% of Jewish elderly.
- The data are less clear on financial need. The Jewish population survey of New Jersey estimated 3% of elderly are living in poverty based on measures of income and living situation. Of those, 2% indicated that they needed financial

assistance in the past year, with a majority (85%) receiving some of the assistance needed. In New Haven, although 2% of elderly were estimated to be living in poverty, nearly twice as many (3.6%) indicated that they needed financial assistance in the past year. Fewer than a quarter of these people indicated that they received assistance.

Living Situation

- A majority of elderly in the United States have at least one child (see Table 15). Nearly 20% (17.8%) of U.S. elderly live with one of their children, and nearly 60% have at least one child nearby. Proximity to children varies across regions. Fewer than 5% of Jewish elderly in New Jersey live with one of their children, and fewer than 30% have at least one child living nearby.

Health Status and Services

- *Fewer than 20% of U.S. adults aged 65 years and older have at least one functional limitation indicated by ADLs or IADLs (see Table 16). The rates are lower (less than 10%) for older adults in the Jewish community surveys of New Haven and New Jersey.*¹² These analyses are based on the subset of ADL/IADLs that were most comparable to those used in the assessment of functional limitations of Hased clients. There are additional ADL/IADL items in the HRS, such as assistance with yardwork, that are not included in this assessment. Including this item, the proportion of adults requiring any ADL/IADL assistance increases to 35%.

Table 15: Children and Living Situation of Population 65 Years and Older in the United States

	HRS 2010	New Haven 2010	NJ Middlesex 2008	Chicago 2010	Baltimore 2010
<i>Children</i>					
Has at least 1 adult child	93.7	89.7	94.4	83.6	91.2
At least 1 child living in household	17.8	6.6	3.8	12.0	--
At least one child living nearby	58.2	40.8	27.9	--	--
<i>Living Situation</i>					
w/ Spouse	62.8	53.2	57.1	53.7	63.7
w/Children	17.8	6.6	3.8	6.7	--
Alone	21.6	39.6	39.3	23.7	28.5
w/Children nearby	53.6	40.8	30.7	61.4	64.5

- *Nearly all (94-95%) of those in need of Home Care services in New Jersey and New Haven received it.*
- Use of Home Care services by those aged 65 years and older in the United States was assessed using the MEPS. For comparison to the Hesed data, hours of Home Care service were categorized into those provided by Home Care Aides, Skilled Medical Professionals, and Other Non-Skilled workers. Home Care Aides are typically affiliated with an agency and provide primarily non-medical services including assistance with daily activities such as bathing, toileting, and meals as well as assistance with household chores such as laundry and light housekeeping. Skilled medical professionals include physicians, registered nurses, physical therapists and others who provide in-home treatment for specific medical conditions such as treatment of wounds, or administering of IV injections. The Home Care Aide is most similar to the type of Home Care provided by Heseds. Distributions of

Home Care hours by type of provider for all elderly in the United States and those in the metropolitan areas of the Northeast are given in Table 17. Figure 12 displays the average number of Home Care hours.

- Overall, the median number of Home Care hours that elderly in the United States receive from Home Care Aides is 50 hours per month. The average number of hours is 117 per month.
- If one sums the median number of hours across the three types of care received, elderly in the United States typically receive 78 hours of Home Care service per month.
- The hours received by elderly in Northeast metropolitan areas, which include New York, is much higher, with a median of 140 hours and an average of over 200 hours of service provided by Home Care Aides, and a total of 228 hours per month if one sums across the median number of hours of service for each type of worker.

Table 16: Health of Population 65 Years and Older in the United States

	HRS 2010	New Ha- ven 2010	NJ Middlesex 2008
<i>Health Status</i>			
Any ADL/IADL	18.5 ^a	9.3	9.5
Mobility inside the home	4.6	4.6	6.2
Dressing	5.9	3.9	4.6
Personal hygiene	8.6	4.3	6.2
Continence	1.7	3.2	4.5
Eating and drinking	2.1	2.0	3.1
Managing medicines	3.0	5.7	6.4
Managing money	6.6	3.6	4.4
Preparing meals	6.2	5.9	6.4
Laundry/Housework	--	6.5	5.7
Grocery shopping	9.2	8.1	7.4
<i>Other Functional Limitations</i>			
Requires supervision	--	10.4	10.8
Vision impairment	6.8 ^b	--	--
Hearing impairment	7.0 ^b	--	--
<i>Services given needs</i>			
Needed home care	18.5 ^c	15.6 ^d	15.2 ^d
Received home care	41.1 ^c	94.3	94.8
Received home care w/ at Least 1 ADL	92.9 ^e	40.0	44.2
Needed assisted living	--	5.8	2.5
Received	--	95.0	76.3
Needed nursing home	--	3.1	2.7
Received	--	100.0	100.0
Needed adult day care	--	2.3	3.6
Received	--	86.1	84.1
Needed meals delivered	--	4.0	4.1
Received	--	82.2	95.5
Needed transportation	--	13.8	13.7
Received	--	90.4	93.0

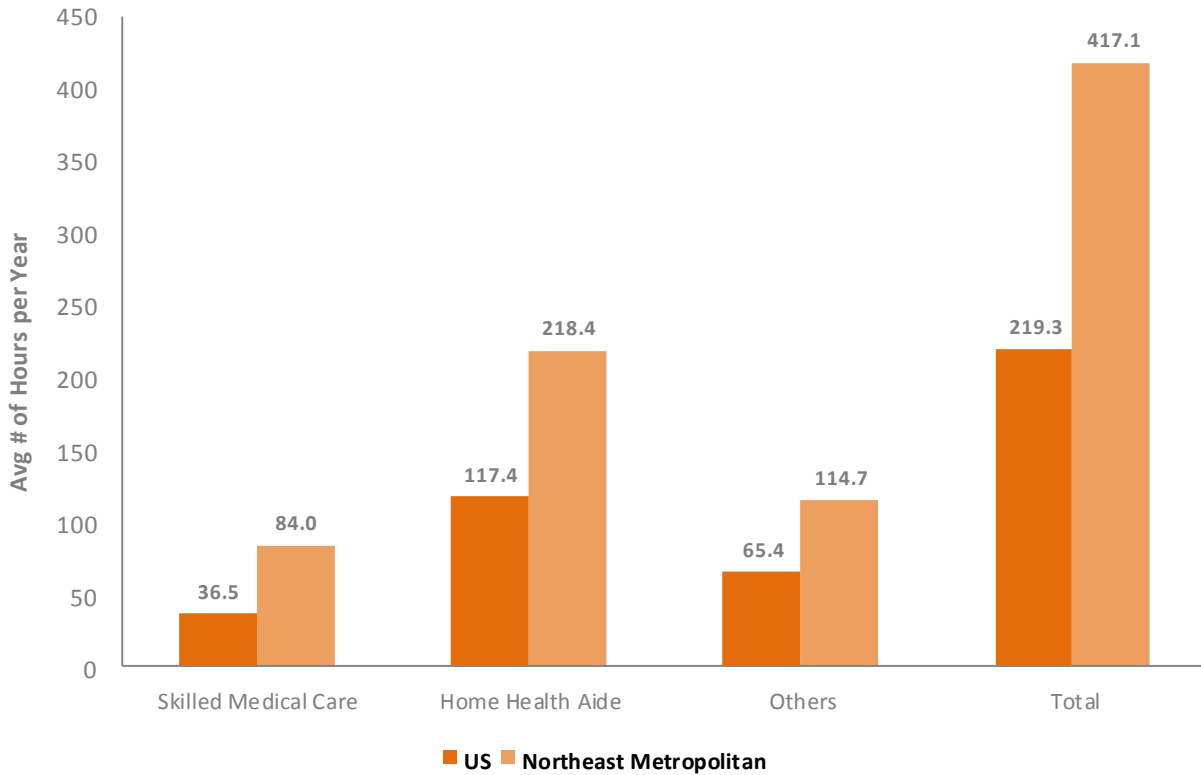
Notes: a) Secondary analysis of section G questionnaire conducted by Brandeis University. b) Represents the percentage who reported their hearing and vision were poor on scales of 1 (excellent) to 5 (poor). c) Needing of Home Care service based on *any functional limitations* as assessed by IADL or ADL. d) Self-reported need for Home Care services and receiving Home Care, independent from ADL/IADL assessment. e) Secondary analysis of MEPS 2009 conducted by Brandeis University, percent of all those aged 65 years and older who received Home Care services and had any functional limitation.

Table 17: Monthly Home Care Hours 2011 by Type of Home Care Worker in United States

	U.S.				Northeast Metropolitan			
	Median	Mean	SD	Max	Median	Mean	SD	Max
Home care aide	50.0	117.4	170.3	672.0	140.0	218.4	214.8	672.0
Skilled medical care provider ^a	4.0	36.5	107.5	672.0	4.0	84.0	203.0	672.0
No skilled home care worker ^b	24.0	65.4	128.2	672.0	84.0	114.7	126.6	672.0
<i>Total</i>	78.0	219.3			228.0	417.1		

Source: Secondary analysis of Medical Expenditure Panel Survey 2009, Brandeis University.
 Notes: a) Skilled worker – trained, certified, or licensed medical personnel. b) Non skilled worker-any type of non-skilled worker who provides home care services such as companion, homemaker and personal.

Figure 12: Average Monthly Home Care Hours of Service Received Among Adults Aged 65 years and Older, 2009.



Total expenditures on Home Health services for people aged 65 and over in the United States were \$28.8 million in 2009 (AHRQ, 2009b). The average monthly expenditures for all who used Home Care services in 2009 are given in Table 18.

- The average cost of Home Care services was \$1,439 per month.
- A majority of those costs were covered by Medicare and Medicaid. A total of

82% of the costs were covered by any public insurance programs including Medicare, Medicaid, workers compensation, state and local governmental insurance programs, Tricare or other Veterans' programs. Just 3% of costs were paid through private insurance. The remaining 16% were paid out of pocket by seniors, their families or other entities.

Table 18: Home Health Care Expenditure for Elders in United States

Average expenditures (monthly)	\$1,439
Sources of Payment (% of total expenditure)	
Public ^a	81.6
Private insurance	2.8
Other private ^b	15.6

Source: Secondary analysis, *Medical Expenditure Panel Survey 2009*.

Notes: a) Medicaid; Medicare; Veterans; Tricare; Other public, federal, state or workers insurance. b) Other private—family or other.

Comparative Analysis

Demographics

Age distribution along with the proportion female, marital status, and living situation for the NNV Hased clients are compared across regions to their counterparts in the United States (see Table 19). The demographic composition of the elderly populations in each region has implications for the supportive services that are needed.

- Elderly Hased clients in Russia and Ukraine are predominantly female.* Seventy percent of elderly clients in Russia and 68% of those in Ukraine are female compared to 56% of all elderly in the United States. Within the United States there is variability across Jewish communities, with the Jewish populations of New Jersey Middlesex

county and New Haven Connecticut at similar proportions as those observed in Russia and Ukraine.

- Elderly in the United States are more likely to be married than those in Russia and Ukraine.* Married households benefit from two sources of pension income and the social support that helps combat the loneliness of aging.
- Over a third of elderly Hased clients live alone, nearly 38% in Russia and 35% in Ukraine. This is a higher proportion compared to all U.S. elderly (22%) but is similar to the proportions of Jewish elderly in New Haven (40%) and New Jersey (39%). The estimated proportion of Jewish elderly living alone in New Haven and New Jersey includes all Jewish elderly, Nazi victims, as well as non-victims. Although today there are

Table 19: Demographic Comparisons: Elderly NNV Hased Clients vs U.S. Elderly						
	Gender (% female)	Age (% 75+)	Marital Status (% married)	Living Alone	w/Children or Family Nearby	w/Children or Family
FSU ^a						
Russia	70.5	40.8	44.2	37.9	48.8	17.9
Ukraine	68.1	31.5	51.7	35.2	49.8	13.1
United States	56.3	45.8	56.7	21.6	58.2	17.8
Jewish Community Studies						
New Haven	65.2	61.8	53.5	39.6	40.8	6.6
New Jersey	70.3	63.1	56.8	39.3	27.9	3.8
Chicago	51.4	51.3	57.8	23.7	61.4 ^a	6.7
Baltimore	57.6	53.9	63.7	28.5	64.5 ^a	--

Notes: a) Percentage among those living alone.

fewer Nazi victims as a proportion of all elderly, our past reports clearly demonstrated that Nazi victims in these regions were twice as likely to live alone than non-Nazi victims (Hahn et al., 2004; Tighe et al., 2007). This fact likely contributes to the higher than average rates of Jewish elderly living alone compared to U.S. elderly as a whole.

Economic and Social Conditions

Comparison of economic status is based on available pension information for NNV Hesed clients in relation to available data on U.S. elderly. Hesed clients are, by definition, impoverished. Rates of poverty among all Jewish elderly in these regions are not possible to assess with data derived solely from those who are known to Hesed centers. In addition, among those who receive Hesed services, we know only reported pension amounts. In many cases, pensions are likely the sole source of income, and, thus, provide

an appropriate comparison to counterparts in the United States for whom more is known about sources of retirement income. We do not have data on the degree to which pensioners might rely on alternative sources of income, such as from work, family, or other sources. No household income is recorded, only pension amounts. Despite these difficulties, some interesting observations can be made about based on this pension information.

- There is a large disparity between the pensions of elderly Hesed NNV clients and elderly in the United States (Table 20). *The median monthly pension of Hesed clients (PPP adjusted) in Russia is less than a third of the social security benefit. Similarly the monthly median pension of Hesed clients (in PPP units) in Ukraine is less than a fifth of the social security benefit in the United States.*

Table 20: Median Monthly Pension Comparisons: Elderly NNV Hesed clients vs. U.S. Elderly

	Local Currency	U.S. Dollar ^a	PPP Adjusted ^a
FSU			
Russia	9,477	294	421
Ukraine	1,013	125	256
United States			
Social Security ^b	1,308	1,308	1,308
Household income ^c		2,994	2,994
Jewish Community Studies ^d			
New Haven		4,000-8,000	4,000-8,000
New Jersey		4,000-8,000	4,000-8,000
Chicago		4,000-8,000	4,000-8,000
Baltimore		2,000-4,000	2,000-4,000

Notes: a) Exchange rates and PPP are given in reference to U.S. dollars (see table 7).

b) U.S. Social Security Administration, Office of Retirement and Disability Policy, http://www.socialsecurity.gov/policy/docs/statcomps/income_pop55/2010/, estimates are for U.S. adults aged 65 years and older.

c) Secondary analysis of HRS household income data for U.S. adults aged 65 years and older, conducted by Brandeis University.

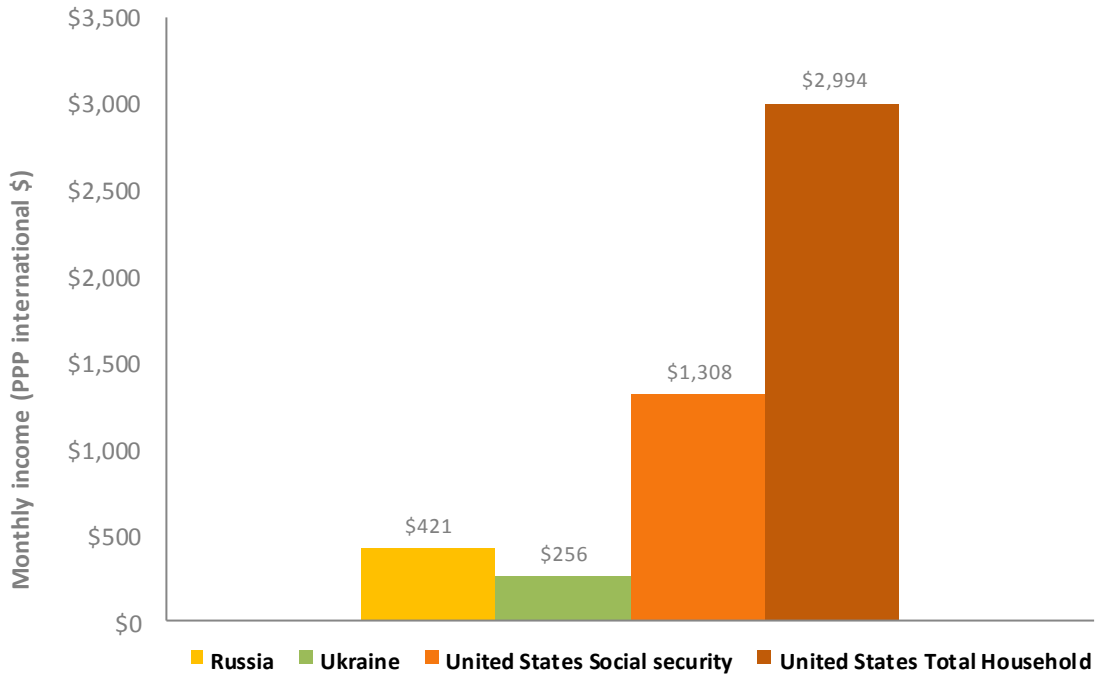
d) The median is an approximation based on the income categories in Table 14.

- *In the United States, income from social security benefits is less than half of the median household income, which highlights that government-funded pensions are not the sole source of income for retirees in the United States, particularly among those of higher income (see Figure 13).*
- *Assessed in international dollars to standardize the currency units, total household income for the typical person*

aged 65 years and older in the United States is more than 10 times greater than the pension income in Ukraine and seven times greater than pension incomes in Russia. Median household income in the United States was \$2,994 in 2011 compared to just \$256 for elderly Hesed NNV clients in Ukraine and \$421 in Russia.

The key issue for understanding the needs of Hesed clients is having some measure of the

Figure 13: Median Monthly Pensions for NNV Hesed Clients in Russia and Ukraine compared to U.S. Median Social Security Benefits and Median Total Household Income for U.S. Adults Aged 65 years and older (PPP International Dollars).



Sources: Hesed client database, U.S. Social Security Administration, Office of Retirement and Disability Policy, http://www.socialsecurity.gov/policy/docs/statcomps/income_pop55/2010/, estimates are for U.S. adults aged 65 years and older. d) Secondary analysis of HRS household income data for U.S. adults aged 65 years and older, conducted by Brandeis University.

degree to which these pension amounts suffice for meeting the financial needs of pensioners. Pension amounts in both countries are based on government estimates of minimum costs of living for pensioners. In Russia, this is currently set at RUB4,961 or \$150 (international dollars), with a higher amount of RUB7,137 or \$230 in Moscow (Alexandrova, 2012). In Ukraine, minimum subsistence for pensioners was \$235 (UAH1,017) as of March 2012 (Ukrainian News Agency, 2012). In both countries, there is debate about the inadequacy of these minimum levels, with the main criticisms that estimation models need to be updated to reflect a basket of goods and services that more accurately reflect the costs to current consumers.

The International Comparison Program (ICP) of the World Bank includes comparison of actual consumer expenditures across countries. The most recent data,

collected for the year 2011 are not yet available. Examining data from IMF 2005, however, provides a useful comparison (see Table 21). The first rows list the estimates of actual individual consumption in international dollars annually for each country, the United States, Russia, and Ukraine. The average expenditures for consumers in the United States were \$31,955 in 2005, compared to just \$7,915 in Russia and \$4,657 in Ukraine.

Expenditures are based to a common set of goods and services calculated across the following categories:

- Food and beverages: representative sample of food products and beverages (alcoholic and nonalcoholic) purchased for consumption at home, as well as tobacco.
- Clothing and footwear: clothing materials and garments, as well as cleaning and repair.

Table 21: Consumer Expenditures Across Countries (International Dollars): 2011

	United States	Russian Federation	Ukraine
ICP 2005 Actual Individual Expenditures			
Annual	31,995	7,918	4,657
Monthly ^a	2,666	660	388
FSU countries as % of US	--	25	15
Adjustment 1: For Inflation	3,066	1,171	829
FSU countries as % of US		38	27
Adjustment 2: US Estimated vs. Actual			
Annual	49,552		
Monthly	4,129	1,463	1,036
% Difference ICP 2011 Estimate vs Actual	26		
Adjustment 3: US Adults 65+			
Annual	32,475		
Monthly	2,706	958	679
US 65+ percent relative to All Consumers	65.5		

Source: World Bank (2008), *International Comparison Program*.

Notes: a) Monthly averages do not include seasonal effects.

- Housing and utilities: rental or ownership costs along with utilities of *water*, electricity, gas, and other fuels. This category also includes maintenance and repair of the dwellings.
- Furnishings and household equipment: expenditures on furniture and furnishings, carpets and other floor coverings, household textiles, appliances, glassware, tableware, utensils, tools and equipment for house and garden, and goods and services for routine household maintenance.
- Health: medical products, appliances and equipment, outpatient services, and hospital services.
- Transport: purchase of vehicles, operation of personal transport equipment, and transport services.
- Communication: postal services and on telephone and telefax equipment and services.
- Recreation and culture: audiovisual, photographic, and information-processing equipment, newspapers, books, stationery, and other recreational items and equipment, including for gardens and pets.
- Education: expenditures on preprimary, primary, secondary, postsecondary, and tertiary education.
- Restaurants and hotels: costs of accommodations including food and beverages.
- Miscellaneous goods and services: expenditures on personal care, personal effects, social protection, insurance, and financial and other services.

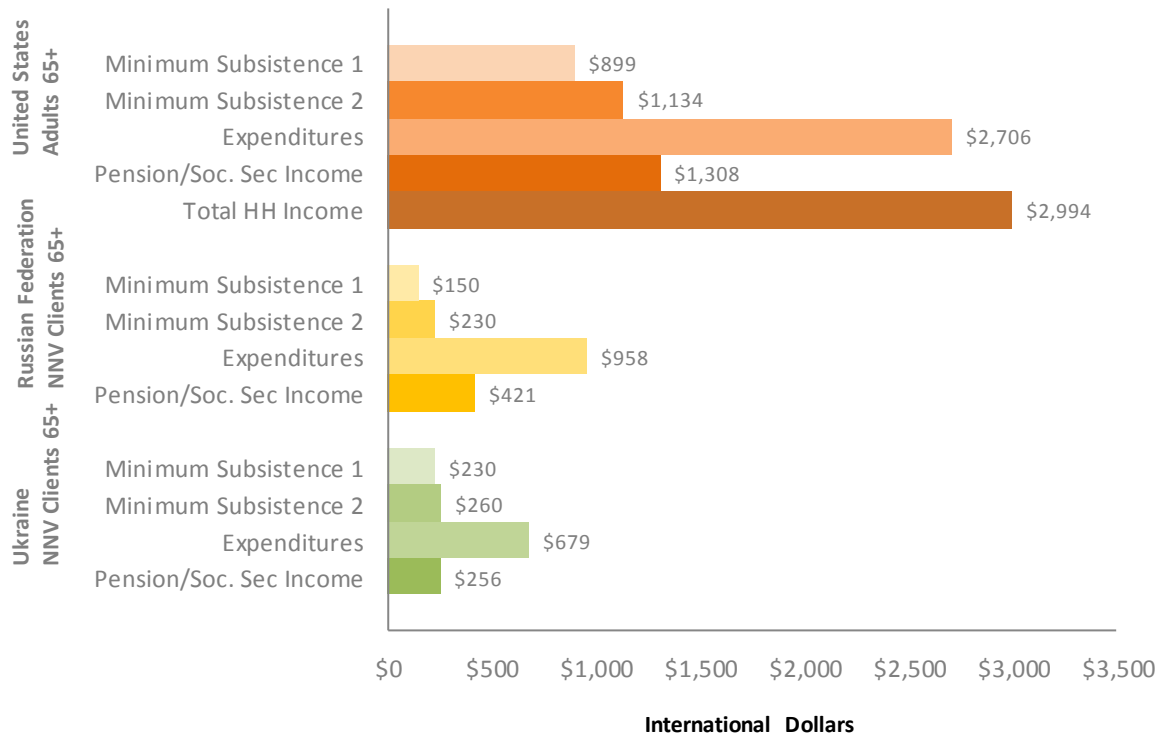
Given the lack of comparable data for the year 2011, the ICP estimates for 2005 were extrapolated to 2011 by applying yearly adjustments for inflation for each year 2006 through 2011.

Adjustments were based to the yearly percent changes in the Consumer Price Index (CPI) within each country.¹³ Average monthly expenditures after adjusting for inflation are given in the row labeled “Adjustment 1” in Table 21. In the United States, unlike Russia and Ukraine, we have regular Consumer Expenditure Surveys (CES) conducted by the Bureau of Labor Statistics (BLS). We compared the most recent BLS estimates for the United States to those obtained by extrapolating the 2005 ICP estimates to 2011 to determine the degree of over- or under-estimation that would result from Adjustment 1. These are given in the rows labeled “Adjustment 2.” The annual expenditures for U.S. consumers in 2011 were \$49,552 annually, or \$4,129 monthly, which is 25% greater than the estimate obtained by simply adjusting the 2005 estimates for inflation. If the estimates for Russia and Ukraine are under-estimated to the same degree as the United States, this would yield average monthly expenditures of \$1,463 in Russia and \$1,036 in Ukraine.

An additional benefit of the CES is that expenditures for seniors, adults aged 65 years and older can be calculated separately. These estimates are given in the row labeled “Adjustment 3.” In the United States, expenditures among seniors were about 65% of those for all consumers—\$32,475 annually, \$2,706 monthly. Again, applying this same restriction on estimates for similarly aged pensioners in Russia and Ukraine, yields monthly estimated costs of \$958 in Russia and \$679 in Ukraine.

The disparity between pension incomes and estimated expenditures—both minimum subsistence and actual—can be seen in Figure 14. For all three regions, two minimum subsistence estimates are provided

Figure 14: Comparison of Consumer Expenditures to Pension Income Across Regions, 2011 (International Dollars).



for the population aged 65 years and older—one for single household and one for two-person households (in recognition of the most common situations of seniors living alone and with spouse). The U.S. estimates represent poverty thresholds for single household (\$899) and two-person households (\$1,134). In Russia, the first minimum represents the national minimum subsistence level for pensioners (\$150), and the second represents the estimate for Moscow (\$230). For Ukraine, the first represents the current minimum (\$230), and the second represents the expected upper end proposed for December 2012 (\$260). Of course, ideally we would define minimums identically across all regions. The variation comes out of practical considerations, based on available published reports. The variation

does, however, highlight the additional considerations that should be taken into account when trying to compare estimates across and within regions. As suggested by each, expenditures for seniors/pensioners depend on a large number of factors including living situation, region, urbanicity, and seasonality. The comparisons we provide here focus on national comparisons that do not account for all of these sources of variation. Also included for comparison are our estimates of 2011 expenditures for adults aged 65 years and older based on the ICP survey. These are compared to pension income (social security income in the United States). In addition, for the United States we include the estimate for total household income, which is not available for pensioners in Russia and Ukraine.

- In Ukraine, the median monthly pension for Hesed NNV clients of \$256 is not much higher than the current minimum subsistence level of \$230. *Thirty-five percent of Hesed clients have pensions lower than the minimum subsistence level.*
- Compared to estimates of actual expenditures based on ICP 2005, *nearly all— 99% of NNV clients in Russia and 97% of NNV clients in Ukraine have pensions below actual expenditures.*
- *Although estimated expenditures are three to four times as high in the United States (\$2,706) compared to Russia (\$958) and Ukraine (\$679), pension incomes are three to four times lower in each region compared to U.S. social security income and 6 – 10 times lower compare to U.S. household income.* Regardless of the actual international dollar amounts associated with expenditures, pensioners in Russia and Ukraine have substantially less income to meet those costs.

As an example of the limitations in the pension incomes to meet actual expenditures, Exhibit 1 displays the costs to citizens in Ukraine for use of social services related to home care. Prices are for citizens with the highest levels of functional limitations. The far right column lists prices in UAH for hours of service. For example, 60 minutes of cleaning requires payment of UAH12.48. For one who needs assistance with basic ADL/IADL functions, a single visit that includes cleaning, food preparation (two meals), help feeding, laundry, bathing, and cleaning bad linens and dressing can cost UAH84 or \$20 international dollars. Within just four visits, one would exceed the difference between the average pension and the government-proposed minimum costs for the basics of shelter, food, and utilities.¹⁴ None of the cost data, either from the ICP or the minimum subsistence, take into account undocumented costs associated with the shadow economy, including undocumented fees for service required to receive medical care from medical professionals.

Exhibit 1: Costs to Citizens in Ukraine for Use of Social Services

ВАРТІСТЬ ПЛАТНИХ ПОСЛУГ СТАНОМ
на III квартал 2011 року
Для громадян з 4 та 5 категорією рухової активності

Перелік платних послуг	Час витрачений на послугу	Вартість платних послуг
1. Ведення домашнього господарства:		
1.1. Прибирання житла: 21,5 кв.м <i>cleaning</i>	60хв.	12,48
а) косметичне прибирання <i>light cleaning</i>	30 хв.	6,24
б) вологе прибирання <i>medium cleaning</i>	70 хв.	14,56
в) генеральне прибирання <i>total cleaning</i>	130 хв.	27,04
1.2. Виконання повсякденних послуг (підготовка продуктів для приготування їжі, миття овочів, фруктів і посуду, винесення сміття, тощо <i>food preparation</i>)	30хв.	6,23
1.3. Розпалювання печей, піднесення вугілля, дров, доставка води (30 хв) <i>burning in firewood/coal</i>	30хв.	6,24
1.4. Миття вікон (30-90 хв)	30хв.	6,24
<i>Window cleaning</i>	60хв.	12,48
1.5. Надання допомоги в обробці присадибної ділянки (0,02 га) (150-240 хв) <i>yard/garden work</i>	150 хв. 240хв.	31,20 49,92
1.6. Дрібний ремонт одягу (10-60 хв.) <i>clothing repair</i>	10 хв. 60 хв.	2,08 12,46
1.7. Прасування (30-60 хв.) <i>laundry</i>	30 хв. 60 хв.	6,24 12,48
2. Придбання і доставка продовольчих, промислових та господарчих товарів, медикаментів, книг і періодичних видань:		
2.1. Купівля та доставка продовольчих, промислових та господарчих товарів першої необхідності (60 хв) <i>shopping</i>	60 хв.	12,45
2.2. Оформлення пільгових рецептів, доставка медикаментів в період лікування (80 хв.) <i>buying prescriptions</i>	80 хв.	16,60
2.3. Купівля періодичної преси, книжок, тощо, читання вголос (30 хв) <i>book buying/reading aloud</i>	30 хв.	6,23
3. Організація харчування:		
3.1. Годування (для ліжкохворих) (40 хв.) <i>feeding</i>	40 хв.	8,32
4. Прання білизни та одягу:		
4.1. Підготовка білизни до прання та її доставка до міської пральні (30-60 хв) <i>preparation of linens</i>	30 хв. 60 хв.	6,25 12,50
5. Надання послуг з використання ремонтних робіт:		
5.1. Надання допомоги в ремонті житлових приміщень (150-240 хв) <i>helping w/ home repair</i>	150 хв. 240 хв.	23,98 38,36
6. Надання допомоги в оплаті комунальних послуг та здійснення інших платежів:		
6.1. Заповнення абонентних книжок, оплата комунальних послуг, звірення платежів, заміна книжок (75 хв) <i>paying utilities</i>	75 хв.	15,53
7. Надання допомоги в оформленні документів та написанні листів		
7.1. Оформлення субсидії для відшкодування витрат на квартиру платі і комунальні послуги (80 хв) <i>filling paperwork for utilities & subsidy</i>	80 хв.	14,36
7.2. Написання листів (30 хв) <i>writing letters</i>	30 хв.	5,39
8. Представництво інтересів в органах державної влади, установах, підприємствах та організаціях:		
8.1. Виконання доручень, пов'язаних з необхідністю відвідування різних організацій (80 хв) <i>errands to different organizations</i>	80 хв.	14,36
9. Забезпечення супроводження:		
9.1. Супровід одиноких непрацездатних громадян в поліклініку (30-120 хв.) <i>accompanying lonely elderly to clinic</i>	30 хв. 60хв. 120 хв.	6,21 12,42 24,84
10. Здійснення профілактичних та санітарно-гігієнічних заходів за місцем проживання (перебування) одинокого непрацездатного громадянина з 5 категорією рухової активності:		
10.1. Надання допомоги при купанні одинокого непрацездатного громадянина, миття голови, розчісування волосся, підрізання нігтів (60 хв) <i>helping bathe lonely elderly, nails</i>	60 хв.	25,19
10.2. Заміна натільної та постільної білизни (10-30 хв) <i>changing linens and dress</i>	10 хв. 30 хв.	4,20 12,60

Health Status and Home Care

National statistics clearly indicate that the expected number of years of life beyond the age of 60 was substantially lower for elderly in Russia and Ukraine compared to their counterparts in the United States. What evidence is there in the data on health status available from Hesed clients and U.S. sources that describe the nature of the disparities in health conditions of elderly in these regions? It is difficult to directly compare the health status of Hesed clients to typical elderly in the United States since much of the difference may be due more to methods of assessment than to actual levels of disability. In the United States, data from the HRS includes detailed assessment of particular health conditions, based primarily on self-report data. The HRS also includes assessment of functional limitations. These latter assessments are similar to those used by Hesed staff in evaluation of needs for Home Care services. The HRS and other local community surveys, however, do not have the type of detailed weighting system or scoring system to yield overall functionality

scores comparable to Hesed. Thus, we compare the overall rates based on presence of any functional limitations that would require human assistance.

- The proportion of adults 65 years and older who have at least one functional limitation and received home care services is 76% among Hesed NNV clients in Russia and 61% in Ukraine (see Table 22). This is higher than the overall proportion among all U.S. adults (41%) and those in New Haven (40%) and New Jersey (44%).
- Among all elderly who received home care service, nearly all in Russia (96%) and Ukraine (96%) had at least one functional limitation. This is similar to the proportion among elderly in the United States (93%) and in New Haven (94%) and New Jersey (95%).
- Although the proportion of elderly people with vision impairment problems appears almost twice as high in Russia and Ukraine than in the United States, the rates are difficult to compare given the different methods of measurement across the regions. For

Table 22: Health Status & Home Care Utilization: Hesed NNV Clients 2011 to U.S. Elderly

	Russia	Ukraine	U.S.	New Haven	New Jersey
Vision Impairment	12.3	16.1	6.8	--	--
Hearing Impairment	8.4	8.7	7.0	--	--
Any Functional Limitations	13.4 ^a	18.6 ^a	18.5	9.3	9.5
% With Any Limitations who Rc'd Home Care Services	76.5	60.8	41.1	40.0	44.2
% Rc'd Home Care Services who had at least 1 Functional Limitation	96.0	96.5	92.9	94.3	94.8

Notes: a) Any limitation across functions similar to those assessed in the United States. These include: mobility, dressing, personal hygiene, continence, eating and drinking, managing medicines, preparing meals, laundry/housework.

Hesed clients, assessments are based on independent ratings of caseworkers who conduct diagnostic evaluations of functional limitations. The U.S. data are based on subjective self-reports of “poor” vision.

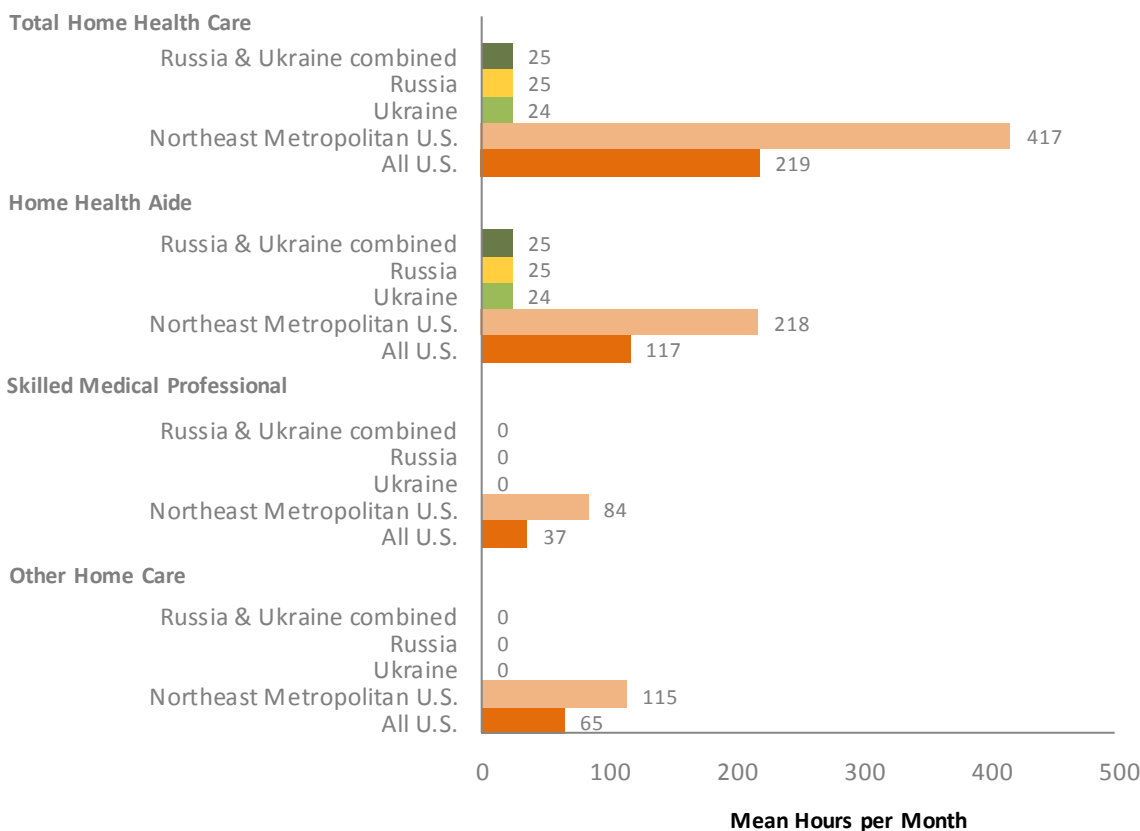
- Elderly NNV Home Care clients in Russia and Ukraine receive nearly 10 times fewer hours of care (~ 25 hours/month) compared to their counterparts in the United States (~ 220 hours per month), and nearly 20 times fewer hours than those in the Northeast Metropolitan

areas (~ 417 hours/month) (see Figure 15).

- Comparing Home Care provided specifically by Home Health Aides, NNV clients receive nearly five times fewer hours than other U.S. elderly and 10 times fewer hours than counterparts in Northeast Metropolitan areas.

The large disparity in average number of hours of Home Care service is due in part to a substantial portion of elderly in the United States who receive full-time care. Twelve percent of elderly who receive Home Care

Figure 15: Average Monthly Home Care Hours by Type of Home Care Worker – Home Health Aide, Skilled Medical Professionals and Other: Russia & Ukraine Hased Clients Compared to Adults 65 years and Older in the United States and Metropolitan Areas in the Northeast.



in the United States, receive 24 hours of care per day. This increases the overall average number of hours. No elderly served by Hesed centers receive this level of Home Care.¹⁵ If those who receive full-time care are omitted, the average number of Home Care hours across Health Aides, Medical Professionals, and Others in the United States is 142 hours and 262 hours in Northeast Metropolitan, still significantly greater than those who receive Hesed Home Care services. For care provided by Home Health Aides, excluding 24-hour care, the average number of hours in the United States is 78 per month and 143 hours per month in Northeast Metro. The overall disparity in hours of service also does not convey variation in level of functioning. For U.S. data we know of the existence of functional limitations but not the extent of the limitation. There is no comparable scale of functionality to compare Home Care hours based on the degree of functioning, such as the limited by 20%, 40%, 60%, 80% scale used by Hesed centers.

Summary

The broad range of demographic, economic, and health conditions as discussed in this section highlight large differences between the elderly population in the United States and in the FSU (as manifested in the Hesed data). In terms of demographics, the proportion of elderly females is much larger in Russia and Ukraine (70% and 68%) than in the United States (56%), and there are more married households in the United States than in Russia and Ukraine.

The large economic disparity between the elderly in the United States and Hesed NNV clients in FSU is evident. United States social security monthly benefits are more than twice the median pensions (in international dollars) of elderly Hesed clients in Russia and more than three times the median pensions of elderly clients in Ukraine. The evidence of the disparities is even greater when one takes into account that in the United States, social security income is less than half of the median household income. Evidence of the large differences in economic situation can also be observed by examining the relation between pension incomes and estimated expenditures. Elderly clients in Russia and Ukraine have substantially less income to meet estimated expenditures.

Although direct comparisons in the health status of Hesed clients and U.S. elderly are limited, the functional limitations of the elderly in United States are clearly in the same order of magnitude as the functional limitations of elderly NNV clients in both Russia and Ukraine. Nevertheless there is a large disparity in the average number of hours of Home Care service that Hesed clients receive. Comparing Home Care provided specifically by Home Health Aides, NNV clients receive nearly five times fewer hours than other U.S. elderly and 10 times fewer hours than counterparts in Northeast Metropolitan areas.

Discussion

It is always difficult to equate living conditions and standards of care across countries. Analysis of available data to compare the economic, health, and social conditions of elderly who receive services from Hesed centers to the conditions of similarly aged counterparts in the United States, however, highlights important differences that can inform our understanding of the needs of elderly in the FSU. Hesed clients are clearly an economically disadvantaged group compared to their counterparts in the United States. Their access to supportive health and social services is far below what is typically available to Jewish elderly in the United States. The economic turbulence and instability in Ukraine may be far greater than that experienced in Russia, but both countries face challenges with respect to effective funding of pension systems. Pensioners in both regions face challenges in their access to needed healthcare services.

Data from national accounts and population dynamics highlight the challenges to the pension systems of Russia and Ukraine. A lower GDP per capita indicates reduced national resources available to fund pension systems and to provide health and other social services for elderly. Trends of an increasing proportion of elderly relative to the total population, and, especially relative to the working age population in Russia and Ukraine also affect national accounts and the resources available for pension systems. Most notable in the analysis of national accounts is the volatility in consumer prices, particularly the sharp increases in consumer prices after the economic crisis of 2008 in Ukraine and Russia compared to the much

slower and consistent rates of increase in the United States. Clearly, economic instability in these countries directly affects those residing in these regions, as well as the efforts of those who seek to provide assistance, as costs of providing food supplements and other services increase dramatically in relatively short periods of time.

Per capita health expenditures are much lower in the FSU, an indication that medical services available to the elderly are more constrained in these countries. Moreover, there are few non-governmental expenditures on health care in the FSU, suggesting increased burdens on the public health care system. Out-of-pocket payments for health as a percentage of total health expenditures is substantially higher in Ukraine and Russia compared to the United States. The lack of public and private insurance coverage in these countries results in increased burdens on household incomes to cover health care costs independently.

National and local Jewish community studies in the United States show that NNV Hesed clients are comparable to the most disadvantaged groups in the United States. Comparisons of pension incomes (in international dollars which adjust for differences in purchasing power), indicate that elderly NNV pensions are just one third to one fifth of the social security income received by U.S. elderly. Elderly NNV clients are in the lowest percentiles of income relative to U.S. counterparts. Elderly NNV clients are also more likely to be female, unmarried, and to live alone compared to their U.S. counterparts.

It is difficult to compare actual health status absent data on assessments of specific medical conditions. For functional limitations (IADL/ADL), Hesed, and U.S. surveys use similar—though not identical—measures. We can, thus, estimate the overall prevalence of any functional limitations fairly consistently across regions. Although the overall rates of NNV clients and U.S. elderly with any limitation are fairly similar, the level of Home Care services each population receives differs significantly. Those in the FSU countries receive far fewer hours of Home Care compared to their U.S. counterparts.

Our visits to Dnepropetrovsk, Melitopol, and Moscow were useful in helping us to understand how to use the data appropriately, in particular, how best to compare Hesed data to sources of data in the United States and supplement our analyses with alternative sources of data. The data that are collected by Hesed staff (as well as by JFS and JCC) as part of budget and case-management are an extraordinary source of data with which to be able to describe the situation within Jewish communities of the FSU. To those of us outside of the FSU, there is no other systematic source of data on the communities as a whole that can be brought to bear to answer important questions about the living conditions and needs within the Jewish community. The investment in designing this data collection system, including the investment of local staff to keep records updated and maintained is impressive.

One key issue that arose in our conversations with Hesed staff was the need to better demonstrate the gap between the needs of their clients and the level of service they are able to provide relative to those needs. For example, material support is

provided to essentially all elderly clients. The level of material support that is provided relative to these needs cannot, currently, be derived from the Hesed database. So, while Hesed staff felt they were not able to provide the same level of support given the same level of needs to NNV clients as to NV clients, we are only able to portray with the data that they all do receive some kind of material support.

As an alternative, for this report, we compared pension incomes to national level statistics/estimates of costs of living. Unfortunately, there are no existing incontrovertible sources of data on what the true costs of living are in these regions. While the governments propose minimum subsistence levels that guide their decisions on pension amounts, citizens and service providers scoff that the government estimates are unreasonably low. We provided examples of news articles related to the arguments around the latest releases of minimum subsistence levels in this report. As researchers, we looked to sources of data that were sensitive to and attuned to variability in measurement across countries and would allow for cross-country comparisons. The data, however, are outdated for current purposes (based to 2005). Although we provided adjustments to 2005 estimates to project what these might appear when considered in a 2011 economy in each country, the fact remains that the national-level estimates we used for comparison may or may not accurately reflect true costs for Hesed clients in these countries, particularly given their insensitivity to variations within a country, such as costs of living within urban areas versus periphery.

Hesed centers also described detailed data they collected on the amount of material

support provided to clients, which could be used to examine the percent of needs that are met, or un-met, as the case might be, when combined with data on expenditures and income. Essentially, these data could serve as a source of actual consumer expenditures specific to elderly Hesed NNV clients. We understand that the level of detail in these data, in the context of what serves primarily as an administrative tool, makes it difficult to establish the reliability of these data across Hesed centers. It might be useful, however, in a future study to explore the feasibility of use of some of the more detailed data that are collected, perhaps in a small number of Hesed centers, which could then serve as measure of reliability of approaches that that rely on macro-level, country-level indicators to infer needs of individuals. The locally collected data would be more useful, especially given controversies within FSU countries associated with debates about the government set “minimum subsistence” levels that are used to determine pension amounts.

Throughout our visit there were some consistent themes across sites that could not be represented in our data and analyses. These include, to a large degree, the unique challenges associated with economies that are still much in transition. For example, in Ukraine, although government agencies recognize the need to provide services and desire to fully fund pensions for all, not only for government workers as in past Soviet economy, the reality on the ground is that there are insufficient funds. Many agencies receive and are forced to work with operating budgets at 20% of need, or 20% of that required to provide the level of services for which they are responsible. Health care is available to all at fixed costs. Yet, all,

regardless of ability to pay, face hidden costs that are required to actually receive care from providers.

In Ukraine, pensioners who are guaranteed free transportation face grossly underfunded public transportation systems that simply cannot get them to where they need to go. In Dnepropetrovsk, a system of private transportation companies has evolved to overcome the inadequacies of the public transportation system. Although even these private transport companies are required to accept pensioners at no charge to pensioners, few, if any, will provide service to pensioners who do not pay out of pocket. The number of seats these private minibuses rely on for income are limited and the companies cannot afford, without reimbursement from the government for the rides lost, to provide these services for free. They, therefore, prefer to leave a pensioner on the side of the road, unable to get to needed doctor visits or markets.

Infrastructure and social service systems in Moscow appeared far better organized and maintained (and funded) relative to Ukraine. The primary challenges appeared to do more with the undocumented costs for service and added fees for service. Although far more services are available to pensioners in Moscow, the costs of these services are beyond the means of many Hesed clients. To some extent, it appeared there were additional obstacles for Jewish elderly who seek services through publicly funded social welfare agencies. The work and positive reputation of the Hesed services is known to these agencies and they would prefer to send pensioners to the Heseds for services as a means for reducing the demands on their own limited resources. This appeared to be true in both Moscow and Dnepropetrovsk.

Future work should consider ways to incorporate more direct measures of these additional costs and challenges. One example is given by the Russian Longitudinal Monitoring Survey, conducted by researchers at the University of North Carolina Population Research Center in collaboration with agencies in Russia such as the Institute of Sociology, Russian Academy of Sciences. This survey, begun in 1992, consists of a nationally representative sample of 4,000 households and is designed to monitor population health and economic conditions in Russia. The survey includes assessment of all costs associated with medical care, including whether there were “unofficial” payments, such as “You paid officially in the cashier’s office in accordance with the official rules or the medical enterprise’s official prices; You paid unofficially through hand-to-hand monetary transactions without any documents; You paid unofficially through gift-giving.” Replicating this type of survey, both for expenditures as well as other needs, within targeted regions where Hesed services are provided would be useful especially if more detailed analyses sensitive to the variability in costs are to be conducted.

Our analyses also do not represent the variability of needs within regions that was conveyed on our visits. The situation and

needs of pensioners in major cities such as Moscow or Kiev differ dramatically from those of pensioners who reside in the outlying regions where government-sponsored social welfare systems are reportedly grossly under-funded. There are far fewer caseworkers available in these regions to cover large geographic areas. Access to medical care and other services is more difficult. Country-level analyses are biased toward the major metropolitan areas where the majority of Hesed clients reside. Future analysis work should examine variation within regions and how attention to this variation influences aggregate, country-level estimates of the conditions of the elderly.

Despite the limitations of the data, and possible lack of sensitivity of our analyses to variability in need within regions of the FSU, the available data on pensions and living circumstances make clear that the economic situation for elderly in the FSU who seek Hesed services are poor. Faced with increasing costs for basic needs such as utilities and food, along with health services including essential medicines and quality care, the pension amounts that Hesed clients rely on are limited.

Notes

¹ See Hahn et al., (2004) for detailed description of the data.

² For macro-economic comparisons of indicators related to healthy aging, Israel is also included for comparison. For some comparisons derived from data from the European Union, where comparable data for the United States is not available, a representative sample of western European countries is included.

³ A quarter of coverage is defined as a period where earnings were at a minimum level required for social security contributions. For example, in 1978 this minimum amount was \$250 per quarter. In 2010, this minimum was an average wage of \$41,673 annually. The quarters of coverage required to be fully insured can be as low as six (18 months).

⁴ These findings were supported by informal reporting during our visits with Hesed staff in Dnepropetrovsk, Melitopol, and Moscow. There was consensus across all with whom we discussed disability categorizations that the government-defined disability categories do not accurately reflect actual disability conditions. Many who should qualify within any of these three groups are unable to navigate the quagmire of bureaucracy. And some suggested it is only the healthiest people who have the stamina to do what is required to attain an official disability status.

⁵ The purchasing power parity or PPP between two countries is a price ratio that measures the number of units of country A's currency that are needed in country A to purchase the same quantity of an individual good or service as one unit of country B's currency will purchase in country B. International dollars are then defined as the purchasing power parities at the global level for each economy and are computed with the United States = 1.00 referred to as "real expenditures in the international dollar." (ICP 2005 report, <http://siteresources.worldbank.org/ICPINT/Resources/icp-final.pdf>).

⁶ Data for the United Kingdom, France, and Germany are provided for comparison in addition to Israel. Centralized data for the United States (e.g., CDC, 2004) are based solely on number of beds in registered nursing home facilities and are not comparable to estimates from other countries which include other assisted living and residential care facilities. For number of nursing home beds, estimates vary across states and regions and can range from a low of 50 beds per 1,000 in Massachusetts to a high of 120 beds per 1,000 in California and New York.

⁷ Hesed Clients are defined as the number of people over 18 who received any Hesed service, excluding children's programs, during the 12 months prior to the reported month and did not die, emigrate, or leave the Hesed during this period. For the purpose of this report and comparison to elderly in the United States, we refer to "Elderly Clients" as clients who are 65 years old or older.

⁸ JDC, Doobov Arieh, personal communication.

⁹ Use of sub-categories with Material Support varies from region to region and among Hesed offices. Thus, no conclusions are drawn about differences in distributions within these sub-categories. It is also not possible to identify the degree of disparity that might exist between

NNV and NV clients in how much material support they receive. Interviews with local JDC staff and Hesed workers on site visits suggested that they are able to provide more support to NV clients than to NNV clients. With administrative data available from the Hesed database, we are able to demonstrate the percentage of clients receiving any type of material support but not how much support they receive, and not how much support relative to their specific needs.

¹⁰ Both the median and the mean number of hours per month are reported. For all groups, there are a few individuals who receive a much larger number of hours than other clients, indicated in the maximum column. In situations where such cases overly influence the estimate of the average number of hours, the median provides a better estimate of the typical number of hours clients of that sort receive.

¹¹ The HRS is sponsored by the National Institute on Aging (grant number NIA U01AG009740) and is conducted by the University of Michigan. Demographic and background characteristics are based on analysis from the early release version of the HRS 2010 datasets prepared and maintained by RAND (<http://www.rand.org/labor/aging/dataproduct.html>). Specific variables, such as number of adult children, living situation, and health conditions are based on analysis of original datasets archived at the University of Michigan (Health and Retirement Study, 2011).

¹² Chicago and Baltimore community surveys did not include assessment of health status and are excluded from the table.

¹³ Source: World Economic Outlook September 2011, International Monetary Fund.

¹⁴ During site visits to Dnepropetrovsk and Melitopol in Ukraine, there was consensus expressed from Hesed staff, as well as a local expert Chernova Lubov, that although these services are on record as available, the experience of most pensioners is that even if there were sufficient pension income to pay for services, the social service system in Ukraine is functioning far below effective service levels. Most programs are under-funded, with as little as 13% of the proposed budget actually allocated. The only service reliably provided by local social workers are those related to ensuring payment of utilities. In Moscow, the impression from Hesed staff and local experts (Antonina Dashkina and Anton Widmer) was that the social service system was functioning more effectively than in Ukraine. Hesed caseworkers do help pensioners negotiate to obtain services that are affordable. In most cases, however, the actual costs of services that are needed exceed pension income.

¹⁵ We asked Hesed caseworkers and managers in Dnep and Moscow about the possibility of 24-hour care for those in need. In Dnepropetrovsk, there was a resounding “no.” Nearly all of the individuals for whom caseworkers provide Home Care reside in conditions that would not be amenable to live-in care. Home Care workers would have to accept living in sub-standard living conditions which is not feasible. The situation in Moscow was very different. A JDC representative suggested that many in the Moscow area do, in fact, arrange live-in Home Care services by offering room and board in exchange for services. Hesed caseworkers, however, said this was not the case for their clients and would be a rare event.

References

- Agency for Healthcare Research and Quality. (2009). *Medical Expenditure Panel Survey*. <http://meps.ahrq.gov/mepsweb/>
- Agency for Healthcare Research and Quality. (2009). Home Health Services-mean and median expenses per person with expense and distribution of expenses by source of payment: United States, 2009. Medical Expenditure Panel Survey Household Component Data. Generated interactively. (September 06, 2012).
- Alexandrova, Lyudmila. (2012). *Pension system worse problem for Russian economy*. ITAR-TASS News Agency. <http://www.itar-tass.com/en/c39/370605.html>
- American Joint Distribution Committee. (2012). *Hesed Client Database*.
- Be'er, Shmuel, Population of Nazi victims in the JDC-FSU Caseload: Projections for 2012-2030. Center for Research on Aging, Myers-JDC-Brookdale Institute, October 24, 2011.
- Becker, C.M., & Merkuryeva, I.S. (2012). Disability incidence and official health status transitions in Russia. *Economics and Human Biology*, 10, 74-88.
- Center for the Study of Aging. (2012). *RAND HRS Data Files*. <http://www.rand.org/labor/aging/dataproduct/hr-data.html>
- Forrester, C. (June, 2011). Needs assessment of elderly clients of the Heseds in four cities in Ukraine. Report prepared for World Jewish Relief.
- Gavrilova & Gavrilov. (2009). *Rapidly aging populations: Russia/Eastern Europe*. In P. Uhlenberg (ed.), *International Handbook of Population Aging*. Springer Science Business Media B.V.
- Gorá, M., Rohozynsky, O., Sinyavskaya, O. (2010). *Pension reform options for Russia and Ukraine: A critical analysis of available options and their expected outcomes*. Economic and Social Consequences of Industrial Restructuring in Russia and Ukraine. Berlin.
- Hahn, A., Hecht, S., Leavitt, T., Saxe, L., & Tighe, E. (2004). *Jewish elderly Nazi victims: A synthesis of comparative information on hardship and need in the United States, Israel, and the Former Soviet Union*. Cohen Center for Modern Jewish Studies. Waltham, MA: Brandeis University.
- Health and Retirement Study, 2010 HRS Cross-Wave: Tracker 2010 File (v.1.0) public use dataset. Produced and distributed by the University of Michigan with funding from the National Institute on Aging (grant number NIA U01AG009740). Ann Arbor, MI, (September, 2011).
- Holzmann, R., Robalino, D., Takayama, N. (2011). *Closing the coverage gap: The role of social pensions and other retirement income transfers*. The International Bank for Reconstruction and Development. Washington, DC: The World Bank.

- Juster, F., Suzman, R. (1995). *An overview of the Health and Retirement Survey. The Journal of Human Resources*, Vol. 30, Special Issue on the Health and Retirement Study: Data Quality and Early Results. Madison: University of Wisconsin Press.
- Kinsella, K., & Velkoff, V. (2001). *An aging world: 2001*. U.S. Census Bureau. Washington DC: U.S. Government Printing Office.
- Margolis, L. (2011). *Addressing the needs of elderly Jews in Former Soviet Union*. UJA-Federation. New York.
- Merkuryeva, I. (2004). The disability benefits in Russia: Estimation of targeting accuracy. Economics Education and Research Consortium Working Paper Series, No. 07/04.
- OANDA. (2012). *Historical exchange rates*. <http://www.oanda.com/currency/historical-rates/>
- OECD Health Data (2011). *U.S. data*. http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT accessed March 30, 2012.
- Social Security Online. *Part 404 – Federal old age, survivors, and disability insurance (1950-)*. http://www.socialsecurity.gov/OP_Home/cfr20/404/404-0000.htm
- Social Security Online. (2012). *Income of the population, 55 or older (2010)*. http://www.socialsecurity.gov/policy/docs/statcomps/income_pop55/2010/
- Spitzer, W. (1987). State of science 1986: Quality of life and functional status as target variables for research. *Journal of Chronic Disease*, 40:465-471.
- Tighe, E., Saxe, L., & Chertok, F. (2007). *Jewish elderly Nazi victim in the Former Soviet Union: An analysis of clients served by Hased service centers*. Cohen Center for Modern Jewish Studies. Waltham MA: Brandeis University.
- World Bank Group. (2008). *Global purchasing power parities and real expenditures: 2005 International Comparison Program*. the International Bank for Reconstruction and Development. Washington, DC; The World Bank, <http://siteresources.worldbank.org/ICPINT/Resources/icp-final.pdf>, accessed April 2, 2012.
- World Bank Group. World dataBank. <http://databank.worldbank.org>, accessed January 16, 2012.
- World Development Indicators and Global Development Finance, World Bank World databank, <http://databank.worldbank.org/>, accessed January 16, 2012.
- World Economic and Financial Surveys. *World economic outlook: Slowing growth, rising risks*. Washington D.C.: International Monetary Fund.
- World Health Organization, Country health profiles, <http://www.who.int/countries/en/>, accessed April 27, 2012.
- World Health Organization, Global health observatory data repository, Life tables. <http://apps.who.int/ghodata/?vid=61740>, accessed January 16, 2012.

World Health Organization/Europe. *European HFA database*. <http://www.euro.who.int/en/what-we-do/data-and-evidence/databases/european-health-for-all-database-hfa-db2>, accessed March 29, 2012.

Ukrainian News Agency. (2012). *Rada denies obliging cabinet initiate increase of minimum subsistence level adjusted for 2011 inflation*. <http://un.ua/eng/article/381365.html>

University of Michigan. (2012). *Health and retirement study*. <http://hrsonline.isr.umich.edu/>

The Maurice and Marilyn Cohen Center for Modern Jewish Studies at Brandeis University is a multi-disciplinary research institute dedicated to the study of American Jewry and religious and cultural identity.

The Steinhardt Social Research Institute, hosted at CMJS, is committed to the development and application of innovative approaches to socio-demographic research for the study of Jewish, religious, and cultural identity.

Map of Russia, courtesy of the University of Texas Libraries, The University of Texas at Austin.

Brandeis University



Maurice and Marilyn Cohen
Center for Modern Jewish Studies