In 2011, the first of more than 70 million baby boomers turned 65, marking the beginning of a major demographic shift in the US population. While this shift will affect the entire country, some states will bear the pressure more than others. In addition, states vary greatly in how prepared they are to address the needs of these aging boomers. Last year, United Health Foundation released the inaugural edition of its America’s Health Rankings® Senior Report, which focused on select health determinants for individuals aged 65 and older and their collective impact on population health at the state level. That report, as well as the annual America’s Health Rankings®, provides targeted metrics that all stakeholders — government, private sector, and nonprofits — should assess when exploring ways to improve the health and well-being of their seniors.

The increase in the US population aged 65 and older makes it imperative that current health service delivery systems have the ability to ensure the health of our future older Americans. According to America’s Health Rankings® Senior Report, the projected increase between 2015 and 2030 in the population aged 65 and older ranges from a relatively low increase of 29 percent in West Virginia to a 100 percent increase, or a doubling, of the older population in Arizona. While the coming demographics has been predicted for more than a decade, as a nation, we are woefully unprepared to deal with one specific and dangerous public health issue facing our seniors — the problem of elder abuse.

Elder abuse is a significant public health and human rights problem. The most recent data available on the prevalence of elder abuse suggests that at least 10 percent of older Americans — approximately 5 million persons — experience emotional, physical, or sexual abuse and neglect each year, and many of them experience it in multiple forms. Older persons are also vulnerable to financial abuse; 5 percent are victims of financial exploitation at the hands of a family member, while other data suggest the percentage of seniors exploited or defrauded by strangers is even higher. The financial loss associated with elder financial abuse alone was estimated to be at least $2.9 billion in 2010, a figure which will likely grow as the number of Americans aged 65 and older increases.

Abuse, both physical and financial, takes a sizeable toll on the health and well-being of our nation’s seniors. On average, older people have more chronic diseases and access the health care system at higher rates than other age groups. Older adults who are victims of violence have additional health care problems and higher premature mortality rates than non-victims. Older victims of even modest forms of abuse have dramatically (300 percent) higher morbidity and mortality rates than non-abused older people. Research has also

demonstrated that older adults who are victims of violence have more health care problems than other older adults, including increased bone or joint problems, digestive problems, depression or anxiety, chronic pain, high blood pressure, and heart problems. In addition, victims of elder abuse have significantly higher levels of psychological distress and lower perceived self-efficacy than older adults who have not been victimized. For older victims of sexual violence the negative health impacts of abuse are even more pronounced. One study found that 12.7 percent of older women in the study group reported a history of sexual assault, all of whom experienced significantly increased risks of breast cancer and arthritis, with those who experienced repeated violence up to 4 times more likely to develop these chronic conditions than women who were never abused.

Not only will older victims of violence be accessing the health care system more, they will be incurring higher health care expenditures than non-victims will. The Agency for Healthcare Research and Quality estimated that $1.9 trillion, or 16 percent of the US gross domestic product, was spent on health care in 2004. It was estimated that $6,280 was spent per person, but that individuals with chronic health problems generate the greatest financial burden on the health care system and account for a disproportionate amount of overall spending. The elderly (aged 65 and older) consumed 36 percent of total US personal health care expenses in 2002, and the average health care expense was $11,089 per year. Of all conditions, trauma ranked as the second most expensive condition in terms of total health care spending.

There is a personal cost, as well. Abuse, neglect, and exploitation threaten seniors’ independence, undermine their dignity, and imperil their physical and financial safety. Considering these factors together—the threat to human dignity and safety, higher utilization rates of health care services by older adults, higher rates of chronic conditions for victims of abuse, and higher treatment costs for both trauma and chronic conditions—we are faced with a human rights, public health, and economic imperative to prevent elder abuse, neglect, and exploitation.

Crafting effective, evidence-based prevention and intervention programs to address this burgeoning problem is predicated on the existence of solid evidence supporting the need for action.
Commentary

Americans will increase understanding of elder abuse is hampered by a number of challenges.

First, elder abuse encompasses a myriad of different types of abuse, including physical abuse, sexual abuse, neglect, financial exploitation, and emotional or psychological abuse. Some states and federal statutes also include self-neglect — instances where an older person fails to meet his or her own physical, psychological, or social needs — as a specific category of abuse. There is currently no comprehensive federal law to provide a unifying set of definitions or practice standards. Therefore, state and local governments have created programs whose interventions reflect the unique parameters of their state authorizing legislation. As a result, historically it has been nearly impossible to gather consistent, national data that could inform the development of best practices for prevention.

Second, gathering good data across such a wide variety of abuse types is complicated by the insidious nature of abuse against the elderly. Similar to domestic violence, elder abuse often takes place in a private residence, with the majority of incidents perpetrated by family members or persons who are familiar to the elder. In addition to the fact that most elder abuse is hidden from view, many elder abuse incidents also go unreported, with as few as 1 out of every 23 cases of abuse of an older person coming to the attention of a criminal justice or social service agency. Yet, unlike domestic violence, elder abuse is not a widely recognized problem and therefore has not been the specific focus of public health detection, intervention, or surveillance efforts.

Making the Case for More and Better Data on Elder Abuse

Federal, state, and local government agencies, private sector health care and social service providers, and academia lack basic information about elder abuse. We do not have a comprehensive estimate of the number of older adults who are victims of abuse, neglect, or exploitation, we have limited information about the characteristics of elder abuse perpetrators, and we know relatively little about risk factors associated with elder abuse or the outcomes experienced by victims. As a result, the ability to evaluate the effectiveness of primary and secondary prevention efforts or intervention protocols for elder abuse is limited.

Collecting more and better data about older Americans will increase understanding of elder abuse, and begin to close these gaps in the collective knowledge about the victims and perpetrators of abuse and exploitation. Specifically, more and better data from across the public health, social service, and criminal justice communities can provide answers to the broad questions below. This will substantially improve our ability to design prevention and response models that effectively address elder abuse, while maintaining the dignity and health of seniors.

What is the scope of the elder abuse problem in the United States? To understand whether federal, state, and local resources can adequately address the needs of older Americans who are victimized, we need to know how much elder abuse actually occurs in the United States. Through improved data collection, we can begin to clarify the scope of the elder abuse problem and develop a more thorough understanding of the experiences of elderly victims of abuse, neglect, and exploitation.

Who are the victims of elder abuse? Efforts aimed at better identifying elder abuse victims can benefit from more and better data on older persons generally. Each specific incident of elder abuse is characterized by a particular confluence of circumstances — the relationship of the victim to the perpetrator, the location where the abuse occurred, the nature of the victimization, the physical and mental health of the victim, injuries sustained and/or monetary loss experienced, etc. However, across a large number of incidents, patterns emerge that show stronger correlations between certain incident characteristics than others. Knowledge of these interrelationships can be used to improve the detection of elder abuse, for instance through the creation or improvement of risk assessment instruments and screening tools, or the implementation of early warning systems for patients or clients.

References:
Who is most at risk for elder abuse? To provide appropriate supports for seniors who are abused, we need to understand who is at risk for particular types of elder abuse. Data on the nature of elder abuse victimizations can provide information on factors that increase the risk for elder abuse, particularly risk factors associated with polyvictimization and revictimization. In addition, it can shed light on factors that protect older victims from some of the more serious negative health ramifications of abuse.

How can we ensure the most positive outcome for victims? Despite the growing body of evidence on the negative impacts of abuse, there is a significant lack of evidence and data about effective methods and practices to prevent elder abuse. Not only is there a dearth of tested prevention models, but multi-component and multi-sectoral interventions are also generally lacking across state systems. Data can provide the basis for crafting interventions and delivering services which provide the most appropriate outcome and benefit for the victim.

Taking Steps to Improve Data on Elder Abuse

In response to the pressing need for current and more comprehensive data on elder abuse, the federal government has engaged in several data collection activities. For example, the US Department of Health and Human Services (HHS) is working to establish a national reporting system that will capture data from state and local Adult Protective Services (APS) agencies across the country. These data will provide information on elder abuse reported to APS, which will improve our understanding of the scope of elder abuse and who the victims are, as well as aid in assessing the resources needed by APS systems to respond effectively to abuse incidents.

Additionally, the Centers for Medicare and Medicaid Services (CMS) in HHS, through its Elder Maltreatment Initiative, is leading an effort to promote the use of elder abuse screening tools by primary care physicians and other clinicians who interact with elderly patients. Data on the use of these screening tools would provide information not only on elder abuse victims, but also on non-victims information which could help us understand more about risk and protective factors associated with elder abuse.

Finally, the US Department of Justice is engaged in preliminary efforts to measure victimization, including neglect and financial abuse, of elderly and disabled adults who reside in nursing homes, assisted living facilities, and other group quarters settings. Seniors residing in these settings are often not included in traditional estimates of elder abuse, as those are often based on surveys of households. Given that the population of seniors in nursing homes and assisted living facilities has a higher rate of cognitive impairment, these data will provide an opportunity to examine the impact of impairment on the risk for, and outcomes of, abuse or exploitation.

Role of the Health Care Community

Although inroads are being made to improve data collection on elder abuse, we know the efforts of the federal government will not be enough to fill in all the gaps in our collective knowledge about this problem. We need the health care community’s help to devise new and innovative ways to comprehensively measure the abuse, neglect, and exploitation experienced by the elderly. Only with improved measurement and surveillance of this issue can we really understand the impact of abuse on the health and safety of older Americans, and reduce health care costs.

Silently, underneath this data, is another truth. In the US, the number of older people is rapidly growing. Predictions indicate that by 2025 the global population of adults aged 60 and older will double to 1.2 billion. Within 20 years, it is estimated that, for the first time in history, the number of older adults will exceed the number of children. As we see more older people, we will see more elder abuse. What do we owe to the 1.2 billion individuals whose life work brought forth the advances in technology, health, science, arts, and life that we take for granted each and every day? As Assistant Secretary for Aging, this issue has become a personal imperative for me, a priority that rises above all others. I must help address and end elder abuse. I am committed to that goal every day, every week. My commitment to our elders is to not be silent. To raise this issue, I need your help. For despite all of our strategies to help seniors maintain the right to make their own choices, to live independently, and to participate fully and actively in community life, those efforts continue to be undermined by the experience of abuse, neglect, and financial exploitation.