KPMG Consulting

Design & Test of Evidence-Based Communications Strategies to Increase Consumer Understanding & Awareness of Long-Term Care Options

BEST PRACTICES REPORT
PART I - LITERATURE REVIEW AND SYNTHESIS OF RESEARCH

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Final Report

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TABLE OF CONTENTS

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OVERVIEW

Statement of the Problem

By 2030, more than 70 million Americans will be over age 65.[1] Approximately 43 percent of those turning age 65 can expect to spend some time in a long-term facility: about half of them will require care for three years or more, and 20 percent will spend five years or longer in a nursing home.[2] In general, however, most Americans are ill-prepared, unaware of their options, and reluctant even to discuss long-term care (LTC) issues. Many Americans are preoccupied or deny the need for LTC and, therefore, fail to plan for it. Others wrongly assume that Medicare or their current health insurance policies will cover the costs of LTC services. As a result, tens of thousands of Americans are impoverished each year by the costs of LTC.

Purpose and Methodology

Barents Group of KPMG Consulting, Inc. conducted a literature review on social marketing/communication theory related to developing a LTC communication campaign, consumers' perspectives of LTC, and consumer behavior around LTC planning. The purpose of this literature review is to provide HCFA with a synthesis of the available information on LTC that can inform communication efforts. Barents synthesized results of various research efforts conducted by Seniors Research Group, the Long Term Care Group, Inc., and the National Council on the Aging (NCOA). In addition, Barents conducted a literature search for articles on LTC using electronic databases, relevant journals, and the Internet.

In general, much of the research on consumer awareness and planning behavior around LTC comes from the insurance industry. As a result, the existing literature focuses mostly on potential buyers of LTC insurance which are only a subset of people that need to plan for LTC. Industry literature may also be limited by its tendency to narrowly define LTC planning as LTC financing. Outside of the insurance industry, the Administration on Aging and a few other organizations have conducted limited research on the subject, including surveys and focus groups. However, there is clearly a need for further consumer-based research to better understand how to communicate LTC issues and influence planning behavior around this issue.

[1] Viatical Settlements and High Net Worth Transactions: "New Uses for Affluent Policyholders." *Journal of the American Society of CLU & ChFC,* November, 1998.
[2] "Financial Gerontology." *Journal of the American Society of CLU & ChFC*, May 1997.

THEORETICAL BASIS AND MODELS FOR HEALTH COMMUNICATION AND SOCIAL MARKETING

Health communication and social marketing methods and practices draw on the disciplines of mass communication, health education, public health, marketing, and social psychology. While both fields share much in common, each sees the other as a critical sub-component of its own work. Rather than engage in this debate, we choose to use the terms health communication and social marketing interchangeably. This interdisciplinary approach uses a number of theories and models that are briefly outlined below.

Social Marketing

The field of social marketing grew from the belief of marketing professionals that marketing principles could be used to sell ideas in addition to commercial products. Social marketing uses commercial marketing principles and techniques to advance a social cause, idea, or behavior. The method was first applied in family planning programs in developing countries (in the 1970s) to promote condom and oral contraceptive use. Application of social marketing strategies then spread to other types of health programs and to other countries. Examples of well-known U.S. programs that have used a social marketing approach include the National High Blood Pressure Program, the Stanford Five City Project, the Pawtucket Heart Health Program, and the Partnership for a Drug Free America.[3,4,5,6,7,8]

Social marketers face unique challenges, which differ from commercial marketing; often, there is negative demand for products or services, less flexibility in modifying products to meet consumer demands, difficulty in asking consumers to change personal habits and adopting behaviors with intangible benefits, and targeting non-literate audiences with limited resources.[9] Social marketers use consumer research methods to determine consumers' perceptions of product, price, place and promotion, and then develop strategic plans which reshape these marketing elements. Efforts must be continually monitored and evaluated in order to allow for modifications if their strategies are ineffective, target groups' expectations change, or when new consumers emerge. Social marketing provides a framework in which marketing concepts can be

[3] Bellicha, Terry and McGrath, John. "Mass media approaches to reducing cardiovascular disease risk." *Public Health Reports*, May-Jun 1990, 105, pp. 245-252.

[4] Farquhar, John, et. al. "Effects of Community-wide Education on Cardiovascular Disease Risk Factors: The Stanford Five-City Project." *Journal of The American Medical Association*, Vol. 264, No. 3,18 Jul 1990, pp. 359-365.

[5] Schooler, Caroline and Sundar, S. Shyam, "Effects of the Stanford Five-City Project Media Advocacy Program." *Health Education Quarterly*, Aug 1996, Vol. 23, Issue 3, pp. 346-365.

[6] Levin, Sarah, et al. "The evolution of a physical activity campaign; Community Interventions." *Family and Community Health*, April 1998,, No. 1, Vol. 21, p. 65.

[7] Lasater, Thomas M., et al. "The Role of Churches in Disease Prevention Research Studies." *1986 U.S. Department of Health and Human Services, Public Health Reports*, March 1986, Vol. 101, pp. 125-131.

[8] Montoya, Isaac D., Trevino, Roberto A. and Ataabadi, Ali N. "The Impact of Public Health Media Campaigns on Drug Users." *Marketing Health Services*, 1997 Winter, p. 20.

[9] Bryant, Carol et al. "Increasing Consumer Satisfaction in the Special Supplemental Nutrition Program for Women, Infants & Children." *Marketing Health Services*, 22 Dec 1998, pp. 5-27.

integrated with psychological theories of behavior change to develop interventions aimed at changing risk factors among a targeted segment of the population. In consumer research and health program monitoring, the consumers are given the role of the expert, and their opinions and reactions serve as the basis for program planning.[10,11,12,13]

Health Communication

Health communication is the study and use of methods to inform and influence individual and community decisions that enhance health.[14] Health communication theory uses four key elements of the communication process: audience, message, source, and channel.

First, a target audience is identified and studied. Audiences may be segmented according to demographics, behavior, and psychographic characteristics. When segmenting by behavior, several models can be used to structure behavior categories, and these will be explored in later sections of the review. Next, health communication theory incorporates social marketing principles to tailor messages to target audiences. Messages should be clear and simple, positive, and both emotional and rational; if they arouse fear, they show ways of alleviating the fear, and if they contain motivational appeals, the appeals follow established guidelines likely to produce the expected response. The source must be credible; often testimonials or anecdotes are useful in creating an effective response. The effectiveness of the message also depends on the channel, the means by which the message is sent. Communication channels can include mass media, news media, popular entertainment, media advocacy, and interpersonal communication.

Health Communication Wheel and Consumer-Based Health Communication

Several models are used to apply social marketing principles to health communication efforts. Based on principles of social marketing, Centers for Disease Control and Prevention (CDC) has used the Health Communication Wheel as the conceptual and planning paradigm to integrate health communication into prevention activities. The Wheel sets out 10 steps for the health communication process:

Step 1. Review Background Information: Uses environmental scanning of epidemiological and behavioral science data to identify the problem and define the scope of the communication activities.

Step 2. Set Communication Objectives: Focuses on determining what change is desired and setting attainable, time-specific, and measurable objectives.

[10] Bryant, et al. 1998.
[11] Freimuth Vicki, Linnan Huan W. and Potter, Polyxeni. "Communicating the Threat of Emerging Infections to the Public." *CDC Emerging Infectious Diseases*, Jul-Aug 2000, vol. 6, No. 4.
[12] Fox, Patrick J, Breuer, Wendy, Wright, Janice A. "Effects of a Health Promotion Program on Sustaining Health Behaviors in Older Adults." *American Journal of Preventive Medicine*, 1997 13 (4).
[13] Sutton, Sharyn M., Balch, George, Lefebvre, R. Craig. "Strategic Questions for Consumer-Based Health Communications." *Public Health Reports*, Nov/Dec 1995, pp. 725-733.
[14] Freimuth, et al. 2000.

Step 3. Analyze and Segment the Target Audiences: Uses existing data and formative research strategies to identify relevant characteristics of the target audience as well as to understand their knowledge, attitudes, and behaviors.

Step 4. Identify Message Concepts and Pretest: Uses formative research methods to determine the most effective strategies or motivators for the target audience.

Step 5. Select Communication Channels: Considers which channels are most credible and accessible to the target audience, matches the channels with the message concept, and defines the appropriate mix of channels.

Step 6. Create Messages/Materials and Pretest: Determines the suitability and effectiveness of the messages and materials.

Step 7. Develop Promotion Plan: Establishes a comprehensive plan for the campaign, including descriptions of the intended audience and channel selection.

Step 8. Implement Communication Strategies: Includes process evaluation of communication activities.

Step 9. Assess Effect: Uses effectiveness evaluation to determine short- and long-term changes in knowledge, attitudes, behavior, and health status.

Step 10. Feedback: Is an ongoing process that can identify areas for improvement and provide a foundation for the development of future communication activities.

Consumer-based health communications (CBHC) operates within Step 3 of the Wheel. CBHC is a form of social marketing which uses consumer research to understand the consumer's reality in order to transform scientific recommendations into message strategies which apply to the consumer. In this social marketing context, a consumer includes any potential receiver of the communications effort. The consumer-based health communications approach aims to develop messages which originate from the consumers themselves, instead of the organization or group that is promoting the message. The approach attempts to avoid miscommunication about the health message by crafting it with consumers during research and testing of the message.[15] Approaches that do not carefully and consistently take the consumer perspective into account can be misconstrued; for example, in efforts to promote mammography screening, a message was sent out to women that women with breast cancer in their family medical history were at greater risk of having breast cancer themselves. When applied to the general public during consumer testing, it was found that the message that women were receiving was that if they did not have breast cancer in their family, they had nothing to worry about.[16]

CBHC attempts to answer six questions:

[15] Sutton, et. al. 1995.
[16] Romans, M.C., et al.: "Utilization of screening mammography – 1990." *Women's Health Issues* 1:68-73 (1991).

1. Who will be the target consumers and what are they like?

   It is important to identify a target audience and identify their specific characteristics. For example, in an effort to encourage cancer prevention through healthy eating habits, the 5-A-Day campaign collected data from focus groups, mall intercept interviews, a national survey, and two national survey databases.[17] After analysis of this data, the 5-A-Day campaign selected a target audience of people who would be receptive to behavior change. The 5-A-Day team mapped scenarios in which people might buy, serve, or eat fruits and vegetables after examining experience, theoretical considerations, consumer research, and answers to key questions about the target audience. Characteristics of this audience, such as having children who would be a secondary target audience, having a hectic lifestyle, valuing convenience in selecting and preparing foods, and seeing cancer as the health problem to be most concerned about, were important to identify before mapping out strategy.

2. What action should the target person take as a direct result of the communication?

   The 5-A-Day team mapped scenarios in which people might buy, serve, or eat fruits and vegetables, and identified potential obstacles to desired actions and ways to overcome these obstacles. For example, if preparation time is an obstacle, a consumer can buy pre-cut vegetables.

3. What reward should the message promise the consumer?

   The 5-A-Day program attempted to create a fair exchange in its promised reward: "If I (target) add two servings of fruits and vegetables the easy way instead of making it hard (action), then I will feel relieved and more in control of my life (reward)."

4. How can the promise be made credible?

   The message must be credible; the 5-A-Day campaign used the National Cancer Institute and the Federal government as authorities who certified the benefits of diet change to include more fruits and vegetables.

5. What communication openings and vehicles should be used?

   Communication openings and vehicles are also important factors. The 5-A-Day program used radio, advertisements at bus stops and on buses, and grocery store programs.

6. What image should distinguish the action?

   A planned image will give a consistent look and feel to all communications and lend further credibility and reinforcement of the message.

[17] Sutton, et. al. 1995.

The immediate product of CBHC process is a strategy statement that lays out who the target consumer is, what action should be taken, what to promise and how to make the promise credible, how and when to reach the audience, and what image to convey. The strategy statement guides the communications efforts, and identifies the most important leveraging points with respect to the consumer.

Other Theories and Models

Many other theories and frameworks provide an understanding of how change occurs at the individual, interpersonal, and community levels. Health communication and social marketing professionals may use a single theory or draw components from several theories in developing a program. Some of the theories most commonly used in health promotion and communication follow.

Individual-Level Theories

Ultimately, most health communication and social marketing efforts seek to change individual behavior. A variety of theories, many from the field of psychology, explain human behavior at the individual level. Individual-level theories focus on characteristics of the individual such as knowledge, attitudes, beliefs, motivation, self-esteem, past experience, skills, and behavior.

Strategies used to promote changes in individual health behavior often rely on the concept and application of self-efficacy, according to Bandura's Social Learning Theory. In this theory, Bandura states that self-efficacy, the confidence a person feels about performing a particular behavior, is the most important prerequisite for behavior change. Bandura asserts that self-efficacy serves as the foundation of human agency; incentive to act depends on a person's belief that he or she can produce desired effects by his or her actions. Self-efficacy can influence cognitive, motivational, affective and choice processes,[18] which influence goal-directed behavior. When Social Learning Theory is applied to social marketing efforts, these beliefs about self-efficacy may be altered to enable people to change their lives for the better.[19]

Individuals' perceived levels of self-efficacy operate as a regulatory mechanism of human agency.[20] Those with high levels of self-efficacy, who believe that their actions can and will produce desired results, are more likely to set goals and recover quickly from setbacks or failures. Individuals with low levels of self-efficacy may require more prompting to set certain behavior goals and may take more time to negotiate setbacks. Different levels of self-efficacy can affect coping strategies related to problems such as health management or disease prevention; many health promotion programs work to increase and support high levels of self-

[18] Bandura, A. "A sociocognitive analysis of substance abuse: An agentic perspective." *Psychological Science*, May 1999, 10: (3) pp. 214-217.

[19] Bandura A. "Self-efficacy: The foundation of agency" as cited in WJ Perrig (2000) (Ed.), *Control of Human Behavior, Mental Processes and Consciousness*, pp. 17-33.

[20] Bandura, A. *Personal and collective efficacy in human adaptation and change*. In Adair, J.G. & Belanger, D. 1998) eds. "Social, personal and cultural aspects," In *Advances in Psychological Science*, vol. 1, p. 51-71.

efficacy related to health behavior targets.[21] Self-efficacy is thought to be important in sustaining the effect of health education, particularly when health outcomes are favorable.[22]

Bandura's theory of self-efficacy in Social Learning Theory concentrates on the power of example in addition to self-perception. Self-efficacy can be enhanced through either observational learning (social modeling) or participatory learning, and relates to an individual's confidence that he or she can accomplish a specific health goal, such as losing weight or teaching others. Bandura asserts that social modeling can affect behavior as much as direct experience.[23]

A related concept is reciprocal determinism, which recognizes that each individual is both influenced by and an influencer of the social and physical environment.[24] For example, individuals observe and model behaviors demonstrated by the media while the individual's behavior change also alters the environment surrounding a collective target audience.[25] Perceived self-efficacy plays a role in producing environmental conditions and in mediating the impact of environmental conditions on behavior.[26]

Reciprocal determinism and self-efficacy can be used to model, explain, evaluate and monitor health behavior change on an individual and collective level. For example, early developmental work of the Pawtucket Heart Health Program successfully applied Social Learning Theory and the concepts of self-efficacy and reciprocal determinism to a volunteer program that included behavior change efforts and healthy behavior modeling in the areas of smoking cessation, nutrition, blood pressure control, physical fitness and weight loss. The program operated through community organizations which provided socially supportive environments conducive to individual health behavior change. [27] The Chronic Disease Self-Management Program (CDSMP) also used a model based on the Social Learning Theory. CDSMP was a community-based patient self-management education course that incorporated several strategies to enhance self-efficacy, such as weekly action planning and feedback, behavior modeling, reinterpretation of symptoms, group problem-solving, and individual decision-making. A program evaluation demonstrated that observation and exposure to positive role models (in this case, lay leaders with similar backgrounds and diseases) can increase patients' self-efficacy or confidence in their ability to manage their disease.[28]

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[21] Elissa, ES, Bandura, A, Zimbardo, PG. "Escaping homelessness: The influences of self-efficacy and time perspective on coping with homelessness." *Journal of Applied Social Psychology*, Mar. 1999, 29: (3) 575-596.

[22] Lorig, K, Mazonson, PD, Holman, HR. "Evidence suggesting that health education for self-management in patients with chronic arthritis has sustained health benefits while reducing health care costs." *Arthritis and Rheumatism*, 36 (4): April 1993.

[23] Bandura, Albert. *Social Learning Theory*, Prentice-Hall, Englewood Cliffs, N.J. 1977, as cited in http://www.mhhe.com/socscience/comm/bandur-s.mhtml

[24] Lasater, Thomas M. et. al. "The Role of churches in Disease prevention Research Studies." *Public Health Reports*, Mar-Apr 1986, 101; pp. 125-131.

[25] Alcalay, Rina. "The Impact of Mass Communication Campaigns in the Health Field." *Social Science and Medicine*,1983, Vol. 17, No. 2, pp 87-94.

[26] Bandura A. "Self-efficacy: The foundation of agency." as cited in Perrig, W.J. ed. *Control of Human Behavior, Mental Processes and Consciousness*, 2000, p. 17-33.

[27] Lasater, et al. 1986.

[28] Bandura, Albert. "Self-efficacy mechanism in physiological activation and health-promoting behavior." In Madden J.I., Natthysse, S., Barchas J., eds. *Adaptation, Learning and Affect.* 1991:229, as cited in Lorig, Kate et al.

One health communications strategy based on the Social Learning Theory model is the use of popular entertainment to educate the public about health issues. Popular entertainment provides highly visible models for teaching new behavior and also elicits an emotional response that may be a greater influence on behavior than a more rational approach.[29] For example, the Stanford Five-City Project used a communication focus based on Bandura's Social Learning Theory, wherein behavior changes surrounding cardiovascular disease risk factors were introduced via modeling behaviors presented on the radio, on billboards, in pamphlets, and on television.[30] After 30 to 64 months of multi-channel and multifactor education, community risk factors were significantly reduced. The project showed that simple behavior changes are possible through means of mass communication.[31]

One of the most widely applied individual theories for the study of health behavior change is the Health Belief Model, which explains health behavior in terms of four kinds of expectancies: (1) perceived susceptibility to a health condition; (2) perceived severity of the seriousness of the health condition including medical and social consequences; (3) perceived benefits of taking health action; and (4) perceived barriers to undertaking the recommended behavior[32,33]. In this model, beliefs about vulnerability, susceptibility, and barriers/incentives to change health behaviors are important.[34] For example, customers dining at a restaurant read the small print on the menu next to an entrée with raw oysters, "Oysters may pose a health risk if eaten raw." In deciding whether to eat the raw oysters, customers would weigh the pleasure gained against the risk taken (benefits vs. barriers). They would consider the likelihood (susceptibility) and seriousness (severity) of the illness and their capacity to prevent it.[35] However, some argue that this model does not account for the effect of an individual's current health status on health behavior, and it also does not clearly define or consider social normative beliefs and influences.[36] When planning a campaign model, HCFA should pay attention to underlying social or cultural factors which can influence individual health beliefs.

The Transtheoretical Model of Change, often referred to as Stages of Change, concerns an individual's readiness to change. Individuals can be grouped into six stages: precontemplation, contemplation, preparation, action, maintenance, and termination.[37] According to the model, change is not linear. Instead, people spiral through the process with inevitable periods of

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"Evidence Suggesting that a Chronic Disease Self-Management Program can Improve Health Status While Reducing Hospitalization: A Randomized Trial." *Medical Care*, Jan. 1999, Vol. 37 (1), pp. 5-14.

[29] Freimuth, et al., 2000.

[30] Farquhar, John, et al. 1990.

[31] Alcalay, 1983.

[32] Rosenstock and Kirscht, 1974.

[33] Maiman, L.A. and Becker, M. H. "The health belief model: Origins and correlates in psychology theory." In M.H. Becker (Ed.) *The Health Belief Model and personal health behavior*. Thorofare, NJ: C.B. Slack, Inc., 1974, as cited by Kersell, Mary W. et. al. 1985.

[34] Kersell, Mary W. and Milsum, John H. "A systems model of health behavior change." *Behavioral Science*, 30 Jul 1985, Vol. 30 (3) pp. 119-126.

[35] Freimuth, et al., 2000.

[36] Kersell, et. al., 1985.

[37] Prochaska, James O., DiClemente, Carlo C. and Norcross, John C., "In Search of How People Change: Applications to Addictive Behaviors." *American Psychologist*, September 1992, Vol. 47, No. 9, pp. 1102-1114.

relapse.[38] A number of communication campaigns have used stages of change as a theoretical framework, segmenting the audience according to stage of change (e.g., NCI's Five-a-Day for Better Health Campaign, the CDC Director's Physical Activity Challenge, and other programs to promote physical activity, mammography, and wellness).[39,40,41,42,43] The time a targeted consumer spends in each stage varies according to the individual; instead, stages are defined by a clear set of tasks which need to be accomplished before movement to the next stage.[44] These stages of change are systematically integrated with the process of change, as individuals emphasize particular processes of change as they move between stages.[45,46,47]

For example, the Imagine Action campaign (a development out of the Pawtucket Heart Health Program) was a six-week community-based physical activity campaign which targeted non-exercisers based on the Transtheoretical Model of behavior change. This model helped to identify target audiences according to stages of behavior change, and outreach efforts were tailored to motivate participation at each stage. Direct mailings that encouraged initiation or maintenance of exercise programs were tailored to fit participants' level of exercise behavior who were identified in contemplation, preparation or action.[48] This method of outreach helped to keep the message relevant to each consumer in order to motivate the targeted behavior change.

The Consumer Information Processing theory describes how people take in and use health or other information in their decision making. Information processing affects health behavior when people choose health services, providers, and health-related products and when they receive health information and advice. The model posits that decision making is a multistage process in which information is acquired and processed, a decision made and acted upon, and the quality of the decision evaluated.[49] The theory serves as a model for planning strategies to encourage behavior change or maintenance when consumer information, if provided by a credible, familiar source and in an appropriate, understandable form, leads to changes in consumer knowledge and beliefs.[50] For example, in the Food Labeling Reform effort of 1994, the goal was to help consumers understand and use new food labels to make more informed, healthier food choices. Understanding how consumers processed information when making decisions about food was integral to the effectiveness of this program, which aimed to motivate the consumer to take action in five stages: first, the consumer had to be exposed to consistent nutrition information

[38] Prochaska, et. al. 1992.
[39] Hammond, et al., 1997.
[40] Loughery, et al., 1997.
[41] Marcus, BH and Owen, N.. "Motivational readiness, self-efficacy and decision making for exercise." *Journal of Applied Social Psychology*, 1992,; 22 (1), pp. 3-16, as cited by Levin, Sarah, et. al. 1998.
[42] Perko and Cowdry, 1996.
[43] Skinner, C.S., Strecher, V.J., and Hospers, H. "Physicians' recommendations for mammography: do tailored messages make a difference?" *American Journal of Public Health*, Jan 1994, 84 (1), pp. 43-49. 1994.
[44] Prochaska, et.al. 1992.
[45] DiClemente, C.C. et al. "The process of smoking cessation: an analysis of precontemplation, contemplation and preparation stages of change." *Journal of Consulting and Clinical Psychology*, Apr 1991, 59 (2), pp. 295-304.
[46] Prochaska, DiClemente & Norcross, 1992.
[47] Prochaska, et. al. 1992.
[48] Levin, et al. 1998.
[49] Bettman, 1979.
[50] Kersell and Milsum, 1985.

through nutrition information on bags, pamphlets or posters. Secondly, in order to attract consumers' attention, the FDA used a new food label with a colorful, distinctive design which is quick and easy to read and comprehend. Educational programs which emphasized making low-fat choices were one way to help the consumer retain the information. Finally, research showed that consumers made food choices depending on negative nutrients, avoiding fat, cholesterol, sugar and sodium, so the Food Guide Pyramid was designed to assist consumer food selection.[51] One critique of this model argues that Consumer Information Processing fails to account for factors which are not at a strictly cognitive level, such as psychological, social, environmental or physiological factors; one cannot assume that the presence and availability of information alone will automatically motivate consumers to take action.[52]

Interpersonal Level Theories

An understanding of interpersonal communication is also important for health communication programs. The patient-provider interaction is crucial, as providers are an important source of health information and can potentially have a powerful influence on health behavior. Communication within the family, among friends, co-workers and others are also key to understanding health behavior.

Bandura's Social Learning Theory describes both factors internal to the individual (e.g., self-efficacy) and factors external to the individual ("environment and situations") that influence health behavior. The social environment is the source of social support, which can be categorized as emotional support (e.g., empathy, love, caring) and instrumental support (e.g., tangible aid, information). According to the theory, learning is acquired and shaped by rewards and punishments as well as by modeling after other people's behavior; thus, people act in anticipation of consequences of their action and shape their behavior in order to earn rewards or avoid punishments.[53] Project Model Health was a school-based health education effort which aimed to influence adolescent health behavior through approaches derived from social learning theory.[54] Using college-age role models as teachers for middle school students, the program targeted health behaviors in the areas of nutrition, drug use, drinking and driving, and sexuality; later evaluation produced positive outcomes on measures of cigarette smoking and improved food choices.

Models that explain the interaction between patients and health care providers are also of interest as health communication efforts may encourage patient-provider communication about a health topic or use providers as a communication channel. Relevant models and frameworks examine: cognition and information processes to explain how patients understand and recall information from providers; interpersonal skills for effective communication; conflict between patient and

[51] Cronin, Frances J.; Achterber, Cheryl; Sims, Laura S. "Translating nutrition facts into action: helping consumers use the new food label; Food Labeling Reform." *Nutrition Today*, Oct 1993, vol. 28, No. 5, p. 30.
[52] Kersell and Milsum, 1985.
[53] Johnson, Elaine M., et. al., "Theories and Models Supporting Prevention Approaches to Alcohol Problems Among Youth." *Public Health Reports*, Nov-Dec 1988, 103 (6), pp. 578-586.
[54] Moberg, D. Paul and Piper, Douglas L., "An Outcome Evaluation of Project Model Health: A Middle School Health Promotion program." *Health Education Quarterly*, Spring 1990, Vol 17(1), pp. 37-51.

provider perspectives; and the provider's social power to influence patients' attitudes, motivations, and behavior.[55]

The integrated model acknowledges that beliefs will not automatically lead to behavior change unless values and expectancies are also influenced. This model also considers social influences which lead to changes in intentions. Also, the model recognizes that intention change may not result in behavior change unless the individual possesses proper control and coping skills.[56]

Community Level Theories

Health communication efforts sometimes target an organization or community by seeking to change policies that affect health or change environmental factors (e.g., reduce environmental hazards). Thus, theories that explain processes of community development and change and how health innovations are adopted in communities are useful for communication planners.

Roger's model of diffusion of innovation describes how new ideas, products, and social practices spread within a community or society (or from one community or society to another). According to this theory, these elements follow a pattern as they spread through society.[57] Key variables are the characteristics of the innovation, communication channels, and social systems.[58] The theory can be used for audience segmentation, by targeting people at different stages of the diffusion of innovation process. The theory also informs message design; messages should highlight the positive attributes of the innovation that have been found to be essential for successful diffusion (e.g., relative advantage of innovation over previous practices, cost-effectiveness of innovation, and compatibility of innovation with economic and socio-cultural values). It is necessary to identify and incorporate the opinion leaders in the community into the communication chain.[59]

Media advocacy is one method used to promote change in public health policy rather than individual behavior. Advocacy increases media coverage and public visibility of a health issue, shapes debate around an issue, and works to advance effective policy. For example, media coverage of the 1997 hepatitis A outbreak in Michigan may have garnered more support for prevention programs and decision making within the food industry.[60]

Community organization theories emphasize the importance of active participation and the development of communities that can evaluate and solve health problems.[61] The theory uses the structure of the community to enable and empower people to become self-reliant in addressing

[55] Joos and Hickman, 1990.
[56] Kersell and Milsum, 1985.
[57] Rogers, E.M. Diffusion of Innovations, Third Edition, New York: The Free Press, 1983. in Freimuth, et. al. "Communicating the Threat of Emerging Infections to the Public."
[58] Freimuth, et al. 2000.
[59] Alcalay, 1983.
[60] Freimuth, Vicki, et al. "Communicating the Threat of Emerging Infections to the Public." CDC, Jul-Aug 2000, Vol. 6, No. 4.
[61] Minkler, M. "Application of social network support theory to health education: implications for work with the elderly," *Health Education Quarterly* 1981, 8, pp 147-165.

lifestyles related to disease and death.[62] Here, health promotion and intervention strategies are developed out of research, knowledge, and respect for community's culture and organization. Community trust is gained and credibility is established, and community involvement reinforces a feeling of ownership of the program by the community and target audience and enables the community to take an active role in facilitating a change in the attitudes and behavior of its population. Cultural resistance may occur, and a recommended approach is the use of metaphorical methods to ease fears and create a less threatening environment.[63] The community may be based on locality, ethnicity, sexual orientation, occupation, or other shared interests. Community-Based Prevention Marketing is a type of social marketing which uses communication organization theory to structure its efforts in designing, implementing, and evaluating prevention programs. [64] By harnessing community participation, campaigns based on community organization theory may make the programs more sustainable.[65]

For example, the Pawtucket Heart Health Program was a major community research and development project which successfully promoted health behavior change through community organizations such as schools, churches, work sites and civic organizations. Volunteers within these organizations effectively delivered behavior change programming while providing a social system which supported the adoption and maintenance of new behaviors to prevent heart disease.[66,67]

Mass Media Campaigns

In a mass media campaign, there is no opportunity for active audience participation or immediate feedback. Given this limitation, a way to maximize effectiveness is to use community organizations as supplements, encourage close collaboration between producers and researchers, and build evaluative mechanisms into the program so that feedback is given throughout the campaign.[68] It is important for media campaigns to ensure that their target audiences are media consumers; evaluation of media campaigns to influence change in high-risk behavior often finds a lack of relevance of the message to the intended consumer and an absence of communication channels.[69] A mass media campaign's effectiveness can be increased and maintained when supplemented by local or interpersonal supports. For example, the National High Blood Pressure Program (NHBPP) was a national education program which used mass media to promote high blood pressure prevention and monitoring at local organizational levels. Through consumer research, NHBPP developed programs and products that promoted a consistent message and image, fostered local programs sponsored national conferences, and provided news media with current information. The Program's effectiveness also depended on message testing and field

[62] Walker-Shaw, Mary. "Applying community organization to developing health promotion programs in the school community." *Journal of School Health*, 1993, Vol. 63; No. 2; p. 109.
[63] Walker-Shaw, 1993.
[64] Bryant, Carol A., et al. "Community-based prevention marketing: The next steps in disseminating behavior change." *American Journal of Health Behavior*, Jan/Feb 2000, Vol. 24, No. 1, p. 61-68.
[65] Ibid.
[66] Lasater, et al. 1986.
[67] Levin, et al. 1998.
[68] Alcalay, 1983.
[69] Montoya, et al. 1997.

review; NHBPP used focus groups, central location intercept interviews, and gatekeeper review to test messages and materials before the implementation of the campaign.[70]

A mass media campaign was implemented by CDC in 1997 to educate the public about the link between *Helicobacter pylori* infection and ulcers. At that time, 25 million Americans were affected by peptic ulcers, which are caused by infection by H. pylori. A 1995 study showed that the public generally believed that ulcers were caused by stress; 72 percent of those surveyed did not know that ulcers were caused by an infection. Subsequently, affected persons did not seek out medical attention, and many physicians were treating patients without testing for H. pylori. In order to raise awareness of the infection and the cure, focus groups were used to give background research and structure to the campaign.

Campaigns often involve efforts to influence media content through media advocacy. The strategy is to influence the media's agenda in order to shape the public agenda and ultimately the policy agenda.[71] This is based on the idea that the media influence audiences by selecting certain people and events for public attention and by telling the audience what is important about the story. It is important to note, however, that these assumptions do not replace consumer research; the success of the campaign depends on consumer reaction to the media message, and cannot assume a direct causal effect between information and behavior change or action.

In conclusion, these models serve to structure research and consumer education outreach. The models are helpful in organizing a strategy; model structures may also serve as a way to evaluate or continually test the efficacy of the health behavior message on the consumer audience. Overall, "understanding" methods have been encouraged. Some public health programs rely solely on clinical and epidemiological research as the basis for messages.[72] Social marketing and health communication prioritizes the consumer's reality through audience research so that health promotion remains relevant, applicable, and as effective as possible.

[70] Bellicha and McGrath, 1990.
[71] Schooler and Sundar, 1996.
[72] Sutton, et al. 1995.

CONSUMER PERSPECTIVES OF LONG-TERM CARE

Defining Long-Term Care

"Long-term care" is a concept that is not easy to define – there is no common vocabulary surrounding LTC.[73] The definition of LTC is increasingly less clear as the characteristics of and delivery settings for primary, acute, and LTC become harder to differentiate.[74] Physicians, nurses, and insurance companies play pivotal roles in identifying treatment options and delivering acute care. In contrast, families are frequently co-equal beneficiaries of LTC interventions, as the care provided to the elderly disabled person is also important respite for the family caregiver.[75]

LTC refers to the many services used by people who have disabilities or chronic illnesses. The services may be needed for three months or longer and may include in-home help with daily activities, community programs, assisted living services, and care in a nursing home.[76] For many people, LTC involves help from family and friends or regular visits by a home health aide, or, for those who are frail or suffering from dementia, LTC involves moving to a place where professional care is available 24 hours a day.[77] Much of the literature and research shows that most people (consumers and opinion leaders) tend to associate LTC with nursing homes.[78] Also, results of a series of focus groups comprising women of varying ethnic backgrounds and age groups (baby boomers and seniors) regarding planning for LTC revealed that the majority of American women characterize LTC by a lack of independence.[79] Some explained that LTC involves assistance with such basic needs as walking, eating, dressing, or bathing, while others use negative phrases to describe the term.[80,81]

For the purposes of this project, *LTC is not limited to a particular set of services* but refers to the need for assistance or provision of care for persons who have experienced a loss of functional independence due to physical and/or cognitive impairment.

Defining LTC is considered an important part of an awareness campaign, as evidenced by discussions with stakeholders. For example, one articulated goal of a retirement/long-term care campaign in Minnesota is that by 2030 long-term care will be 1) broadened to deal with the

[73] "Proceedings of the HCFA Sponsored Conference on Public Attitudes, Beliefs, Knowledge, and Concerns About Long-Term Care: Goals for a National Long-Term Care Consumer Awareness Campaign," Baltimore, Maryland, December 12, 2000.
[74] Stone, Robyn I. for the Millbank Memorial Fund – "Long-Term Care for the Elderly with Disabilities: Current Policy, Emerging Trends, and Implications for the 21st Century" - August 2000.
[75] Stone & Kemper as cited in Stone, Robyn I. for the Millbank Memorial Fund – "Long-Term Care for the Disabled Elderly: Current Policy, Emerging Trends and Implications for the 21st Century."
[76] AARP - http://www.aarp.org/confacts/health/privltc.html
[77] National Institute on Aging (Age Page) - http://www.nih.gov/nia/health/agepages/longterm.htm
[78] For example, see Fabrizio, McLaughlin, & Associates for the American Health Care Association – Secure Care Opinion Research Program , March 1998.
[79] Matthew Greenwald & Associates for the National Association of Area Agencies on Aging (N4A) – "Voices of Women: Perceptions and Planning for Long Term Care", February 2000.
[80] Ibid.
[81] National Institute on Aging (Age Page) - http://www.nih.gov/nia/health/agepages/longterm.htm

many stages of support for older adults (with nursing homes filling just one niche), and 2) that long-term care in 2030 will stress "functional wellness" or the promotion and management of physical and mental health among older persons, striving to provide older persons with a high quality of life. This emphasis on functional wellness is intended to change the philosophy of long-term *care* into one of long-term *support*.[82]

Knowledge and Awareness of Long-Term Care

Research finds that, while LTC is a concern for older people, it is not a top priority for working age people when asked about their health concerns. While some working age adults are aware of LTC, they do not have a good sense of what it is. They confuse it with other types of medical needs or disabilities. They are also more likely to talk about it as an end-of-life situation rather than the more common situation of extended disability or cognitive limitation.[83] Furthermore, there is a high level of negativity surrounding LTC, complicating awareness.[84]

This lack of awareness of what LTC is translates into an inaccurate understanding of the risks of needing LTC, the costs of care, and who pays for the care when needed. This ambiguity is greatest among younger people. However, research has also shown that those who have experienced a LTC need with a friend or relative have more accurate information about the risks, costs, and financial aspects of care.[85]

The level of awareness of LTC issues varies among different populations, with older people tending to be more conscious of the issues and problems than younger persons. Results of focus groups suggest that LTC was not a salient issue for most baby boomers who were more concerned with child care, college tuition, and mortgages.[86] There are also gender differences in awareness of LTC. Because women tend to have more experience as caregivers for those needing LTC, they also tend to have a better awareness and understanding of the risks, costs and who pays. Men typically express a greater denial that they will one day require some form of LTC, and also tend to have less accurate knowledge about specific LTC needs.[87]

LTC Experience

It is usually a family crisis or a life-altering event that triggers real education in and planning for LTC.[88,89] Adult children participating in focus groups mentioned that LTC had been addressed by their families only as a result of "tragic circumstances" they were forced to confront.[90]

[82] Aging Initiative: Project 2030. Final Report. December 1998.
[83] Long Term Care Group Inc., Attitudes toward Long Term Care: Summary Findings of Qualitative Research since 1994 - February 2001.
[84] HCFA Conference, December 12, 2000.
[85] Long Term Care Group Inc., February 2001.
[86] Matthew Greenwald & Associates, February 2000.
[87] Long Term Care Group Inc., February 2001.
[88] Marsa, Linda, "The New 21st Century Stress, Who Takes Care of Mom and Dad?" *Family Circle*, November 1, 2000.
[89] HCFA Conference, December 12, 2000.
[90] Chavez, Regino, "An Investigation of Attitudes Toward Long-term Care insurance among Selected Target Audiences: Results of Focus Groups for Brown Miller Communications Topline Report," December 16, 2000.

Many people unexpectedly encounter LTC issues when they suddenly find themselves providing care for frail parents or relatives. Between 40-60 percent of the adult population know someone who has required LTC services.[91,92] Twenty-five percent of these reported that they have provided financial assistance for LTC costs.[93]

However, despite the fact that the majority of the adult population has known someone receiving LTC services, such experiences do not necessarily move people to plan for their own LTC needs.[94,95] One study suggests that LTC needs of a parent or relative could serve as a competing factor to an adult child planning for her/himself. Adult children tend to think about LTC needs for the older generation much more frequently than they do for themselves.[96]

Awareness of Available LTC Service Options

Beyond nursing homes, there is a general lack of knowledge and understanding of available LTC service options. A National Investment Conference (NIC) survey found that the majority of consumers did not understand or identify with any of the terms used to describe supportive services communities.[97] The TIAA-CREF survey noted that three-quarters of working-age respondents made the association between LTC and nursing homes, while fewer than half made connections between home health care and LTC. Approximately one-fifth made the connection with assisted living.[98] Similar observations have been widely noted by other studies.[99,100,101] According to one study conducted by Felicia Mebane, 28 percent of adults 50 and older were not familiar with home health care.[102] Of those, almost half were not acquainted with adult day care or congregate living and had not encountered or were familiar with the term assisted living. In comparison, 82 percent did know of skilled nursing facilities.[103] Research also suggests that some minority groups have a significantly lower level of knowledge of the community services available to them than do non-Hispanic whites.[104]

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[91] "Senior Boom," *Credit Union Management*, March 2000.

[92] Granza, Lee, Madamba, Anna, Warshawsky, Mark, "Financing long-term care: Employee needs and attitudes, and the employer's role," *Benefits Quarterly* 14, No. 4, (Fourth Quarter 1998): 60-72.

[93] The NCOA/John Hancock Long-Term Care Survey, Executive Summary," http://www.ncoa.org/news/ltc/ltc_summary.htm, March 1999.

[94] Long Term Care Group, Inc., 2001.

[95] Sweeney, Theresa, "Senior Boom," *Credit Union Management*, Vol. 23, No.3, March 2000, pp. 32-33.

[96] American Council of Life Insurers (ACLI), "Long-Term Care Insurance: An Undiscovered Necessity," http://www.acli.com/public/media/pubs/ltc_undisc.htm, 1999.

[97] National Investment Conference survey. National Housing Survey of Adults Age 60+: Opinions, Attitudes, Perceptions, and Behaviors, cited in "Senior Living: Beyond the Nursing Home," *American Demographics*, November 1, 2000.

[98] Granza, Madamba, Warshawsky, 1998.

[99] Mebane, Felicia, "Want to Understand How Americans Viewed LTC in 1998? Start with Media Coverage," *The Gerontologist* 41, No. 1, (2001): 24-33.

[100] Matthew Greenwald & Associates, February 2000.

[101] Lumpkin, J.,"Retirement Housing and Long-Term Health Care: Attitudes and Perceptions of the Mature Market - Choosing a Retirement/Long-term Care Facility," *Marketing to Women*, February 1993.

[102] Mebane, F., 2001.

[103] Harvard School of Public Health and Louis Harris & Associates, 1995; National Council on Aging and John Hancock mutual Life Insurance Company, 1999.

[104] Moon, Ailee, Lubben, James E., and Villa, Valentine, "Awareness and Utilization of Community Long-Term Care Services by Elderly Korean and Non-Hispanic White Americans." *Gerontologist* 38, No. 3, June 1998: 309-16.

Long-Term Care Beliefs, Opinions, and Attitudes

Research shows that the general population lacks a clear understanding of what LTC is. However, while people may not have many facts or the ability to articulate LTC issues, they do have many feelings and emotions concerning LTC and often use negative phrases to describe the term, including denial, fear of losing independence and becoming a burden to family or friends, concern over not getting adequate care of finding good care, and not being able to afford needed medical care.[105,106,107]

Denial

Denial is a major obstacle for people in considering LTC options and planning.[108] One of the most prevalent consumer or public perceptions is that individuals feel they will never personally be affected by LTC issues or will find themselves in a LTC situation. While people may acknowledge that roughly half of the elderly population will spend at least some time in nursing homes, they do not believe that they will be part of that half.[109,110] For most people, LTC is difficult to accept as something that could apply to oneself.[111] For the care recipients as well as for adult children, there is a tendency to believe that they or their parents are still young, will remain healthy, and will not need LTC.[112] Furthermore, studies indicate that men experience denial more than women do.[113]

Negative Impressions of Long-Term Care

As previously mentioned, when people think of LTC, nursing homes most frequently come to mind. Nursing homes have a poor reputation among the public. Several studies have demonstrated the following images surrounding nursing facilities:

- Overcrowded
- Institutional warehousing
- Poor treatment
- Lack of independence
- Loneliness
- Isolation
- Lack of dignity
- Depressing
- Where people go to die

[105] Long Term Care Group Inc., February 2001.
[106] Matthew Greenwald & Associates, February 2000.
[107] Harris Interactive Inc, on behalf of the Robert Wood Johnson Foundation, Johns Hopkins University, and the Partnership for Solutions, "Chronic Illness and Caregiving", March 17-November 2000 (Q705).
[108] Long Term Care Group Inc., February 2001.
[109] National Council on Aging (NCOA) Conference on "Public Attitudes, Beliefs, Knowledge and Concerns about Long Term Care", December 12, 2000.
[110] Mature Market, February 1993.
[111] Granza, Madamba, Warshawsky, 1998.
[112] Chavez, December 2000.
[113] Long Term Care Group Inc., February 2001.

- Long waiting lists
- Inadequate inspection
- Poor standards for cleanliness
- Improper care
- Problematic staffing[114,115,116]

According to a 1996 Gallup poll, 47 percent of Americans had poor perceptions of nursing home quality.[117] Interviews conducted in 1998 by Arnold Communications for the American Health Care Association (AHCA) discovered that respondents had overwhelmingly negative impressions regarding quality of life at nursing homes. Researchers believe that for caregivers, guilt over the idea of "abandoning" a loved one becomes an influential factor as people form their opinions of nursing homes. For those who are familiar with other LTC residential alternatives, assisted living and home care had more favorable associations. In general, people find staying at home and maintaining independence as long as possible the most appealing option.[118,119] The results from a recent national Harris Interactive survey on perceptions about chronic illness and care conducted by the Partnership for Solutions support these findings, where 64 percent of persons surveyed reported they would prefer to receive care in their own home if they became seriously ill and needed a lot of care, 15 percent would prefer to move in with family, and 15 percent would prefer moving into housing with supportive services (such as assisted living) while only 3 percent would prefer to move into an institution such as a nursing home.[120]

The HCFA Conference on LTC Consumer Awareness in December 2000 revealed key LTC values include independence, dignity, compassion, choice, empowerment, and family issues. A study by AARP focusing on the perceptions that older parents and their adult children have on the meaning of "independent living" suggest that the two generations view "independent living" differently. The study also shows that adult children are more concerned than their parents about the ability of the parents to live on their own.[121]

Becoming a Burden

The fear of becoming a burden to one's children is another great concern for people thinking about LTC.[122,123] Research indicates that the elderly want to avoid having their adult children care for them when they get older, especially if they had the financial capability to seek outside LTC help. However, the same study found that some Hispanics and Native Americans (who tended to fall in lower income brackets) were more willing to consider relying on their children,

[114] Mature Market, February 1993.
[115] Long Term Care Group Inc., February 2001.
[116] Matthew Greenwald & Associates, February 2000.
[117] Haryluk, Markian and Wagner, Lynn, "In The Public Eye," *Provider*, October 1998.
[118] Ibid.
[119] Matthew Greenwald & Associates, February 2000.
[120] Harris Interactive Inc, November 2000. (Q730)
[121] Barrett, L. Connections for Independent Living Research Team, AARP Research Group, "Independent Living: Do Older Parents and Adult Children See It the Same Way?" November 1998.
[122] NCOA/John Hancock, March 1999.
[123] Harris Interactive Inc, November 2000. (Q705)

suggesting a possible cultural influence on preferences of care. Among Asian Americans, many felt their cultures required adult children to be the primary providers of care for aging parents, but also indicated they did not feel the same should apply to their own children. [124]

While many aging persons do not wish to burden their children, they are aware that their children are willing to assume care giving roles.[125,126] Children can provide assistance by handling finances, making arrangements for community services, transportation, and chores.[127] People are more willing to make sacrifices for their parents or in-laws, but are not inclined to ask their children to do the same.[128] The impact on a caregiver's life when taking care of a loved one involves deep, conflicting emotion. Caregivers describe the experience of guilt, burnout, stress, frustration, mental and physical strain, feeling overwhelmed, as well as being grateful for the opportunity to give the care and help their parent.[129] Adult children feel a sense of duty to take on the responsibility if a parent should require LTC, and 58 percent of people with living parents or in-laws say they give LTC for the older generation some or a great deal of thought.[130]

Sources and Types of Information Available on Long-Term Care

In general, seniors turn to the family for information on LTC. Families may be exposed to information on LTC from personal experiences, insurance industry sources, LTC providers, financial planners, state insurance departments, state-run counseling programs, consumer groups, and the media.[131,132,133]

While some caregivers of family members requiring LTC look for assistance within their community, many do not search for outside help or do not know where to begin. Senior centers, hospital social workers, local aging organizations, government agencies, and medical non-profit associations, along with, to a lesser extent, friends and acquaintances, are the usual sources of assistance. According to an AARP study, although adult children are often information sources for and influencers for parents' decisions on LTC, they are not well-informed about their parents' information needs for LTC. The study showed that one-third of them claimed they would not know the type of information their parents would need or where to seek answers. [134]

[124] Matthew Greenwald & Associates, February 2000.
[125] Ibid.
[126] NCOA/John Hancock, March 1999.
[127] Matthew Greenwald & Associates, February 2000.
[128] NCOA/John Hancock, March 1999.
[129] Matthew Greenwald & Associates, February 2000.
[130] ACLI, 1999.
[131] Enabling Informed Consumer Choice in the Long-Term Care Insurance Market, *Journal of Aging & Social Policy*; 10(3), 1999.
[132] HCFA Conference, December 12, 2000.
[133] Bloom, DL et al. Making Decisions About Long-Term Care: Voices of Elderly People and Their Families. SPRY Foundation: Washington, DC. February 1996.
[134] Barrett, November 1998.

According to focus groups conducted for the California Partnership for Long Term Care, good ways to reach seniors include television, radio, magazines, and daily newspapers.[135] Findings from the HCFA Conference on LTC Consumer Awareness, however, show that, print ads are not useful for conveying information on LTC to seniors, while the Internet, radio, and personal counselors, such as those of the Senior Health Insurance Assistance Programs (SHIPS) seem to be more promising.[136]

Some minority populations are faced with fewer sources of information. For example, Native Americans report their ability to find assistance is limited by the lack of services and resources available on reservations.[137] Previous research by Barents found that the Hispanic population as a whole is not receiving intended health messages that target the general population.[138] (See Appendix 1. "Communications and Marketing to the Hispanic/Latino Population.") Similarly, those in rural areas also indicate a lack of access to information and services typically available in areas closer to cities.[139]

[135] Public Relations Implications of Consumer Focus Groups and Agent Interviews, Conducted by Brown-Miller Communications for the California Partnership for Long Term Care, February 13, 2000.
[136] HCFA Conference, December 12, 2000.
[137] Matthew Greenwald & Associates, February 2000.
[138] Barents Group, *Development and Testing of Medicare Quality Performance Materials for Hispanic/Latino Beneficiaries and Intermediaries Serving Them*, Health Care Financing Administration, January 2000.
[139] Matthew Greenwald & Associates, February 2000.

LONG-TERM CARE PLANNING AND OPTIONS

Health Psychology/Health Planning

Several studies by Shelly Taylor, et al. suggest that people who engage in *proactive coping* plan for adverse events before they occur. They identify potential situations and devise a plan for living their lives in such a way that accounts for any unfortunate circumstances that may arise, thus avoiding or minimizing the situation's impact. An *initial appraisal* determines the potential effect of the situation and prompts people to plan according to the degree of urgency.[140]

Initial coping efforts include planning and information seeking. Planners or potential planners, therefore, should be supported as much as possible and provided with resources and channels for further information.[141] When in a planning frame of mind, they are more receptive to messages and more realistic than they may be during the stage where they are implementing a course of action. Early on in coping with an adverse event, people generally have a realistic sense of their own strengths and weaknesses, as well as their environment. However, the window for reaching people is greatly diminished once a person makes a decision. Taylor finds that those who have already decided a plan of action are less inclined to re-think their choices, advantages and disadvantages, and alternative paths.[142,143,144]

Taylor suggests that visualization can aid planning, particularly if this exercise is exhaustive. By merely reading a persuasive argument or envisioning outcomes, a person is not necessarily equipped to know what steps to take to achieve that outcome. In addition to envisioning an outcome, people need to visualize the processes involved in planning for that outcome. Through *mental simulation*, people can envision a situation as it is likely to take place, considering relationships, sequence of events, and temporal and spatial factors. In envisioning the plan, they may remember more details than if they had not pictured it. The premise of mental simulation is that by imagining a scenario, people are more apt to plan for its details.[145]

A favorable environment in which planning and proactive coping behaviors are cultivated include a close support network of family and friends. Conversely, people with few resources, including a lack of close family ties, financial constraints, or little time to think through situations may be at a loss for planning. Disposition also plays a role, with optimistic people more inclined to hear messages and take steps for prevention.[146]

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[140] Aspinwell LG; Taylor SE. "A Stitch in Time: Self-Regulation and Proactive Coping." *Psychological Bulletin*. 1997:121(3):417-436.
[141] Ibid.
[142] Taylor SE; Armor DA. "Positive Illusions and Coping with Adversity." *Journal of Personality*. December 1996;64(4):873-898.
[143] Taylor SE; Brown JD. "Positive Illusions and Well-Being Revisited: Separating Fact from Fiction." *Psychological Bulletin*. 1994;116(1):21-27.
[144] Taylor SE; Gollwitzer PM. "Effects of Mindset on Positive Illusions." *Journal of Personality and Social Psychology*. 1995;69(2)213-226.
[145] Taylor SE; Pham LB; Rivkin ID; Armor DA. "Harnessing the Imagination." *American Psychologist*. April 1998;53(4):429-439.
[146] Aspinwell; Taylor, 1997.

Taylor's theory of *cognitive adaptation* states that when someone experiences a troubling experience, that person will evaluate the event, its greater meaning to one's own life, and how to regain a sense of control. It would follow that someone who has had a firsthand experience with LTC would be receptive to planning messages. After having undergone a traumatic event, they would be apt to want to maintain a sense of control within their own lives; taking control could involve active planning for contingencies in their own future.[147]

Planning for Long-Term Care

A recent Harris Interactive survey on perceptions about chronic illness and care showed that almost 50 percent of persons not currently suffering from any type of chronic illness think they are "somewhat likely" likely to develop a chronic medical condition in their lifetime (while 17 percent feel they are "very likely" and 12 percent feel they are "very unlikely" to develop a chronic condition). The same survey showed that 32 percent of persons surveyed would rely on their spouse or partner if they needed ongoing help with personal or medical needs if suffering from a chronic condition, while 32 percent would rely on other family members, 13 percent would rely on children or grandchildren, and 5 percent would rely on friends. [148]

However, even if they are aware or familiar with LTC issues, families are often reluctant to discuss and plan for LTC. In prior research, the Long Term Care Group found that, while people often worry about how they will pay for and find needed LTC services, they tend not to make plans for the provision of that care. Literature from other sources illustrates a similar pattern: people are aware of the possibility of needing LTC, but for a variety of reasons they rarely prepare for it.

For example, half of all baby boomers indicate that they have given hardly any or no thought to how they will pay for their LTC needs.[149] Furthermore, many older parents and adult children express the opinion that discussing LTC arrangements with their children or parents would be easy, but few have actually done so.[150,151,152] Denial, fear of becoming a burden, or awkwardness are often cited as reasons for avoiding a discussion on LTC.[153] Focus groups have also revealed cultural differences when discussing LTC options among family members. Women, Asians, Hispanics, and Native Americans tend to report more conflicts between extended, as well as immediate, family members when having to make decisions about LTC.[154]

Americans are doing very little planning for their LTC needs. A survey conducted by the Roper Organization shows that few people (12 percent) are giving careful thought to what they will do if they or their spouses require LTC, but 60 percent reported giving *little to no thought* on how

[147] Taylor SE. "Adjustment to Threatening Events: A Theory of Cognitive Adaptation." *American Psychologist.* November 1983;38:1161-1173.
[148] Harris Interactive Inc, November 2000. (Q700)
[149] Fabrizio, McLaughlin & Associates, on behalf of the American Health Care Association. January 1999.
[150] Barrett, November 1998.
[151] AARP, "Independent Living: Adult Children's Perceptions of their Parents; Needs -- Easy to Say, Hard to Do,"
[152] NCOA/John Hancock, March 1999.
[153] Chavez, December 2000.
[154] Matthew Greenwald & Associates, February 2000.

they might manage LTC needs.[155] Similarly, in assessing their preparedness for LTC, 38 percent of respondents claimed they had made some preparations, while another 35 percent claimed to have made no arrangements.[156]

Fifteen percent of those interviewed in the Harris Interactive survey on chronic illness and care reported "not being able to afford needed medical care" as their biggest worry about having chronic illness.[157] However, over 50 percent of Americans are not saving money to pay for LTC.[158]

A series of in-depth interviews conducted by Setting Priorities for Retirement Years (SPRY) Foundation in 1994 with consumers and their families identified four long-term care decision-making styles: 1) scramblers in a time of crisis, 2) reluctant consenters (who are pushed to make decisions by relatives of health care professionals), 3) people responding to a "wake up call," and 4) advance planners who research care alternatives and make plans while they are still healthy. Across most types, consumers express a common interest in not burdening relatives with their care. In addition, the study group of advance planners (16 residing in CCRCs and three in assisted living or home care situations) shared the following characteristics:

- They set their own deadlines (often coinciding with a milestone) for moving or changing their living arrangement;
- They made plans in other areas of their lives;
- They seemed to accept old age as a natural part of life; and,
- They wanted to make their care decision independently (with family playing a supportive rather than decisive role).

Interview suggested that advance planners, more so than other groups, had lived through LTC crises with their own parents or other relatives. Advance planners in the study tended to be affluent and healthy. Because of their relatively good health, they were looking for LTC environments that meet their emotional and social needs (in addition to providing on-site care as needed). The SPRY study suggested that incentives for planning are lessened by changing LTC choices, no personal experience with trying to care for an elderly person, limited exposure to chronic health problems, perceptions that care is costly or difficult to arrange, and limited resources.[159]

Few studies in the LTC literature document when people start planning for future LTC needs (in cases where they do). According to a study in the early 1990s, among seniors living independently but considering moving to a retirement facility, the prime age to begin seeking information on options was 70-79. The same study showed that those elderly persons currently living in retirement facilities had started the decision making process between 60 and 80 years of

[155] ACLI, 1999.
[156] NCOA/John Hancock, March 1999.
[157] Harris Interactive Inc, November 2000. (Q705)
[158] HCFA Conference, December 12, 2000.
[159] Bloom, 1996.

age.[160] In an audit conducted for a Minnesota public awareness campaign, professionals involved in financial planning, insurance, and consumer advocacy observed that that planning for lifestyle issues (including retirement housing) becomes serious three to five years prior to a person's retirement. Planning for retirement is also accelerated when people face the "empty nest" syndrome. [161]

According to the Long Term Care Group, literature "suggests that certain key elements are critical to encouraging and enabling people to plan ahead to meet their LTC needs. Attitudes emerge as much more important factors associated with planning behaviors than do demographic characteristics. This suggests that planning behaviors are susceptible to change if education and information is directed at shaping and changing people's attitudes." Tell at al. identified the following types of information, that, if provided, would encourage people to plan for LTC needs:

- An understanding of what LTC is;
- The fact that LTC is not covered by Medicare;
- The limitations of relying on Medicaid; and
- The various options for meeting LTC needs.

Perceptions on Long-Term Care Financing

The literature consistently shows that individuals do not have accurate information about who pays for LTC. There is common misperception, particularly among African-Americans and Hispanics, that such services will be covered by Medicare, current health insurance coverage, or pension plans.[162]

Several studies have found that most respondents say "Medicare will pay" if they need care at home or in a nursing home for more than three months (see Table 1). The "don't know" response is more common among working age adults, and the "Medicare will pay" response is more common among retirees. This finding is understandable since working age adults have little exposure to Medicare and even have less understanding of the benefits covered by Medicare. Furthermore, the "don't know" response probably reflects the fairly low level of thought they have given to LTC needs.

In contrast, retirees are more likely to say that Medicare will pay for LTC if they need it. This would suggest that, once people become more familiar with Medicare coverage, they misunderstand the depth of coverage it would provide for their LTC needs. Because retirees read information about skilled nursing home care and at-home care in the *Medicare and You* guide and other sources, they form the impression that Medicare would provide for their LTC needs. As individuals approach the age of relying on Medicare, their sense that Medicare will cover extended care needs actually *increases*, not decreases.

[160] Mature Market, February 1993.
[161] Himle Horner for the Minnesota Department of Human Services, Baby Boomer Market Research Report, June 1997.
[162] HCFA Conference, December 12, 2000.

Retirees are slightly more likely than active employees to believe that they would have to pay for LTC from their own pockets. Perhaps because direct experience with LTC increases as one gets older, retirees develop somewhat more realistic understanding of who pays for LTC.

Table 1: How Would You Pay for an Extended LTC Need?

	Retirees	*Actives*
Medicare Will Pay	62%	30%
Self Will Pay	34%	29%
Don't Know	19%	36%

Source: Aggregate response to numerous surveys. Long-Term Care Group, Inc. 2001

Individual's reservations about being able to pay for LTC and finding adequate LTC have also changed over time, probably as a result of the growing need for care and greater public awareness. Results of a survey conducted in 1984 indicated that 40 percent were worried about how they were going to pay for LTC. In 1994, this number rose to 73 percent and in 1998 it reached 85 percent. Concern over paying for care presumably has increased as individuals have become more aware that the government reimbursement for LTC is limited unless substantial depletion of assets occurs.

Interestingly, individuals worry as much if not more about how they will find adequate care as they worry about paying for care. Those worried over finding adequate care increased from 50 percent in 1984 to 89 percent in 1994 and 91 percent in 1999.

There is no difference between the responses of active employees and retirees with respect to concerns with finding adequate LTC. Although working age adults have less knowledge of financing LTC, they have a general impression that the care system is fragmented and difficult to navigate.

Long-Term Care Insurance As An Option

While individuals express their reservations about being able to pay for and find adequate care, they are not familiar with how to address these concerns. Some individuals hope that they will not need LTC and consequently have not planned for it. For those who realize that they may require LTC, some have expressed the willingness to pay for it out-of-pocket or rely on Medicaid. Others will rely on family members to provide or pay for the care.

There has been an increased awareness of LTC insurance as an option for financing LTC. In a general population survey conducted by the Health Insurance Association of America (HIAA) in 1995, only 38 percent of respondents age 55 and over were aware of private LTC insurance as an option. In the most recent 1999 general population survey, the awareness of private insurance as an option increased to 63 percent. While awareness of LTC insurance has increased, individuals overestimate the cost of coverage. When asked to cite typical premium costs, people cite much higher costs than are actually representative of current coverage.

Impressions of Long-Term Care Insurance As An Option

Individuals have varied impressions of LTC insurance as an option to finance their LTC needs. This section summarizes survey and focus group findings for individuals in the general population, not specifically those that have made a decision to buy or not buy LTC insurance. When asked to describe the benefits of having LTC insurance, financial protection and relief from being a potential burden on family or friends are often cited (see Table 2). Individuals indicate that having insurance means they do not have to worry about how to pay for the care they might need. Other perceived benefits include: providing peace of mind and freedom of choice of the type of care and care settings one can use. This can translate into a better quality of life and a greater sense of control.

Table 2. What Do People Perceive as the Advantages of Obtaining LTC Insurance?

	Retirees	*Actives*
Not Be Burden to Family	36%	33%
Protect Savings	23%	27%
Peace of Mind	16%	18%
Protect Spouse	14%	11%
Freedom of Choice	9%	8%

Source: Aggregate response to numerous surveys. Long Term Care Group, Inc. 2001

The negative impressions people have about LTC insurance generally focus on the cost of the premium and competing priorities for their discretionary income (see Table 3). In general, objections based on cost reflect their perceived value of the coverage relative to its price, rather than being a true measure of affordability. (This is supported by the fact that across different levels of income and assets there is no difference in the response that insurance costs too much. Individuals consistently over-estimate the cost of LTC insurance premiums.) Other respondents feel insurance is not necessary because it would be okay to rely on family for care, or because they would not need LTC.

Table 3. What do People Perceive as the Negatives of Obtaining LTC Insurance?

	Retirees	*Actives*
Costs Too Much	45%	45%
Too Confusing to Think About	18%	18%
Okay to Rely on Family	13%	10%
Okay to Use Up Assets	11%	10%
Won't Need Care	10%	9%

Source: Aggregate response to numerous surveys. Long Term Care Group, Inc. 2001

In focus groups, individuals talk about their concern that the insurance will be "wasted" if they buy it and then do not need to use it. There are also concerns about what the insurance covers and whether it would be there in the future when the care is necessary. Some respondents mention the concern that it would be hard to qualify for the coverage.

In summary, there is a distinct lack of awareness regarding the risks, cost, and who pays for LTC. Despite a denial of the need for LTC, many are worried about paying for and finding care. This is compounded by misinformation about funding and identifying options.

Barriers to Purchasing Long-Term Care Insurance

Since the inception of LTC insurance in the mid-1980s, the market for such products has grown substantially. By June 1998, 119 insurance companies had sold over 5.8 million policies.[163] The LTC insurance market is concentrated among a small number of companies. Twelve insurance companies represent approximately 80 percent of the policies sold in the individual and group association market.

The three main markets for LTC insurance include: the individual and group association market; the employer-sponsored market; and the life insurance market. An overwhelming majority (80 percent) of the policies in-force have been sold through the individual and group association market. Sales through the employer-sponsored and life insurance market account for the remaining 20 percent.[164] The employer-sponsored market is a promising venue for the sale of LTC insurance. It provides an opportunity to reach a wider audience that is typically younger than the average purchaser of LTC insurance.[165]

While the LTC insurance market may be growing, still only a small fraction of Americans purchase LTC insurance. It is estimated that only about 10 percent of the elderly population are covered by LTC insurance.[166]

The reasons for low market penetration for LTC insurance stem from barriers on both the demand and the supply sides (see Table 4). Key factors that have limited the sale of LTC insurance include: plan affordability, lack of knowledge about the risks of LTC, and misconceptions of public and private programs. On the supply side, barriers include lack of data, lack of interest from large group markets, and regulatory concerns.[167],[168]

Table 4. Barriers to Long-Term Care Insurance

CONSUMER DEMAND BARRIERS	SUPPLY BARRIERS
Affordability	Lack of data for pricing risk
Lack of information	Lack of interest from large groups
Misconceptions of public and private programs	Uncertainty of tax status
Perception or denial of need	Evolving regulatory standards
Complexity of product	
Uncertainty over value of product	
Consumer confusion	

[163] However, it is estimated that only between 55 percent and 65 percent of policies sold are currently in-force.
[164] Tilly, et. al., The Urban Institute in collaboration with the Congressional Research Service (CRS), Long-Term Care Chart Book: Persons Served, Payors, and Spending. May 5, 2000.
[165] The average age of an employee electing this type of insurance coverage is 43 years.
[166] Weiner, et. al., 2000.
[167] Alecxih and Kennell, 1991.
[168] Weiner, et. al, 1994.

Insurance Companies' Approach to Selling Long-Term Care Insurance

With much of LTC insurance being sold on the individual and group association market, insurance companies must rely on direct marketing techniques, namely brokers and agents to sell LTC insurance. Few insurance companies use direct mail to market LTC insurance products. Insurance brokers and agents are important information pathways for consumers. Brokers and agents focus on the lack of public awareness of the need for LTC insurance by informing individuals of the financial risks associated with LTC and explaining the limited protection offered by public programs.

Focus groups conducted with LTC insurance brokers and agents in 1999 provided their view of success sales and marketing strategies to sell LTC insurance.[169] Brokers and agents generate interest in LTC insurance using a variety of marketing strategies. To generate initial interest in LTC insurance, brokers and agents may send a *pre-approach letter* to an existing client base and provide follow-up. For individual consumers, some of the more effective approaches include relationship-building with centers of influence (e.g. certified public accountants, financial advisors, and attorneys). For employer groups, brokers and agents present LTC insurance as an executive fringe benefit. Once the broker or agent has *a foot in the door*, the vast majority believe the best way to identify interest in LTC insurance is to let the client reveal the need through a guided interview conversation. Many respondents believe that you have to sell LTC insurance as an investment in their future.

Profile of LTC Insurance Buyer and Non-Buyers

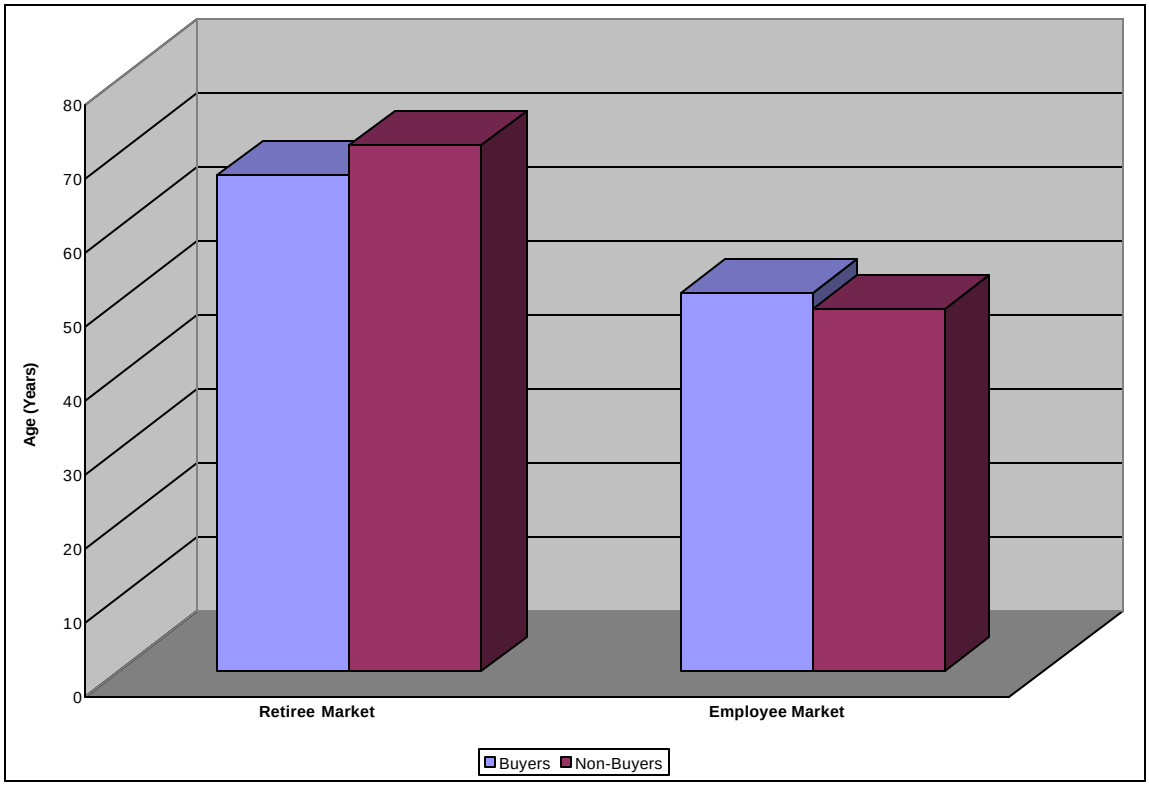
Despite the misinformation and conflicting attitudes, some people still plan ahead for their LTC needs by purchasing LTC insurance. Seven studies conducted between 1987 and 1999 help illuminate the key differences between buyers and non-buyers. They identify the motivators as well as the barriers to planning ahead.

While demographic differences between buyers and non-buyers have been identified in various studies, they emerge as less important or consistent differentiators between buyers and non-buyers across these various surveys. In contrast, attitudes more consistently differentiate buying behavior. These differences remain when we look at people both *before* and *after* they make a decision to buy or to not buy.

The demographic factors examined focus on age, income and assets, gender, marital status, education and the presence of children. In the retiree market, buyers tend to be younger than non-buyers (age 67 versus age 71) and are more likely to be female (55 percent versus 52 percent). Conversely, in the employee market, buyers tend to be slightly older than non-buyers (age 51 versus age 49), and are more likely to be male (38 percent versus 33 percent). No consistent differences emerge with respect to marital status across these studies.

[169] Seniors Research Group (SRG), 2001.

Figure 1. Age Difference Between Buyers and Non-Buyers



Source: Aggregate response to numerous surveys. Long-Term Care Group, Inc. 2001

With respect to education and income, buyers are more likely to be college graduates, have higher income and greater assets, and have a higher propensity to save (through IRAs, mutual funds or annuities). Buyers also are more likely than non-buyers to perceive their health as excellent. Buyers are also less likely to have children living nearby.

Attitudes are also different among buyers and non-buyers (see Table 5). Buyers say that it is important to plan ahead for LTC needs and that, without insurance, they would pay on their own for LTC. Buyers are also much more likely to have had a personal experience with LTC and to see themselves at risk of needing LTC.

Table 5. Attitudes of Buyers Versus Non-Buyers

	Buyers	*Non-Buyers*
Important to plan ahead	80%	48%
Self will pay	67%	35%
Likely to need LTC	65%	55%
Have had family experience with LTC	40%	30%

Source: Aggregate response to numerous surveys. Long-Term Care Group, Inc. 2001

Having some type of LTC experience with a family member or friend has been a consistent trend among buyers. In studies conducted each year from 1997 to 2000, individuals who buy LTC insurance are consistently more likely to have had some family experience with LTC. This direct, personal experience has illustrated for them some important factors regarding LTC. These individuals recognize the need for LTC. In addition, they realize LTC is expensive and not covered by Medicare. Finally, planning for LTC is one strategy to meet this need.

There are also differences between buyers and non-buyers with respect to how they learn about LTC and the process by which they decide to buy coverage (see Table 6). Buyers are more likely to have heard about LTC from a trusted source, been affiliated with the sponsor longer, and had more direct or prior contact with the sponsor. For example, buyers may have made other purchases through the sponsor. This suggests that the "planning ahead" message may be best sent through a trusted sponsoring entity that has a prior relationship with the target audience.

Buyers are also more likely to recall elements of the educational campaign, attend a seminar or workplace meeting to learn more about LTC, or have made a prior inquiry. They are also more likely to discuss the decision with others such as their spouse, their children, friends, their agent or other specialist. Buyers are also more likely to do comparison-shopping when considering LTC insurance.

Table 6. Differences in LTC Decision-Making Process Between Buyers and Non-Buyers

	Buyers	*Non-Buyers*
Recall elements of the educational campaign	81%	69%
Discussed decision with spouse	68%	59%
Discussed decision with friends	46%	28%
Discussed with agent or specialist	32%	13%
Discussed decision with children	24%	10%
Did comparison shopping	45%	27%
Made a prior inquiry	38%	27%
Attended seminar or meeting	27%	17%

Source: Aggregate response to numerous surveys. Long-Term Care Group, Inc. 2001

Buyers and non-buyers have distinct attitudes about insurance in general (see Table 7). Buyers are more likely to believe that the insurance is not a waste of their money compared to non-buyers who believe it is better to save on their own. They also have confidence that the insurance will pay as promised. In contrast, non-buyers have distrust of insurance companies: non-buyers are more likely to think that sales people are only concerned with the sale, that insurance companies cannot keep their promises, and that premiums will increase.

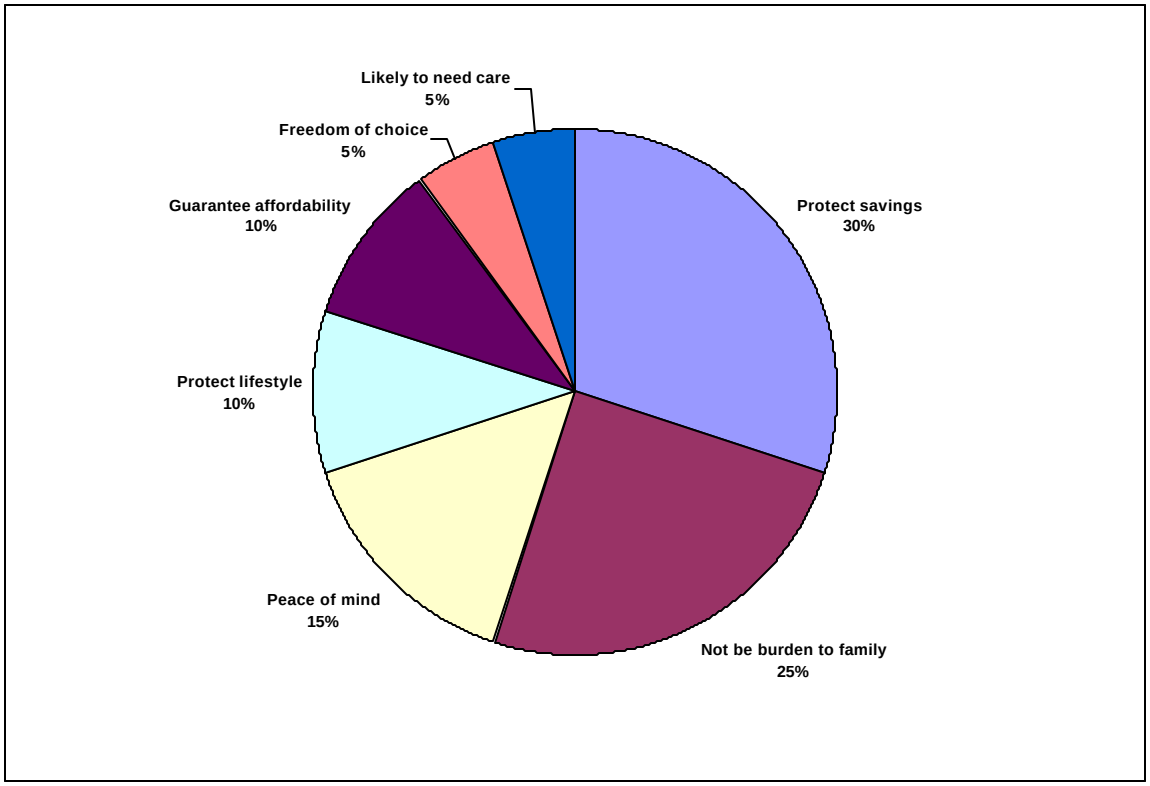
Table 7. Attitudes About Insurance Between Buyers and Non-Buyers

	Buyers	*Non-Buyers*
LTC is not a waste of money	82%	40%
Premiums will increase	64%	86%
Premiums reasonable for services provided	45%	10%
Sales people are only concerned with making a sale	39%	61%
Insurance companies almost never deliver what they promise	26%	45%
Too many conditions must be met before benefits are paid	22%	52%

Source: Ritchey, Atchley and Seltzer, 1991.

When buyers are asked why they purchased LTC insurance, a number of reasons are cited (see Figure 2). The reason mentioned most often is to protect savings. Not being a burden to family and peace of mind are also important. Protecting one's lifestyle and quality of life and to guarantee affordability of care are also cited.

Figure 2. Reasons For Buying Long-Term Care Insurance

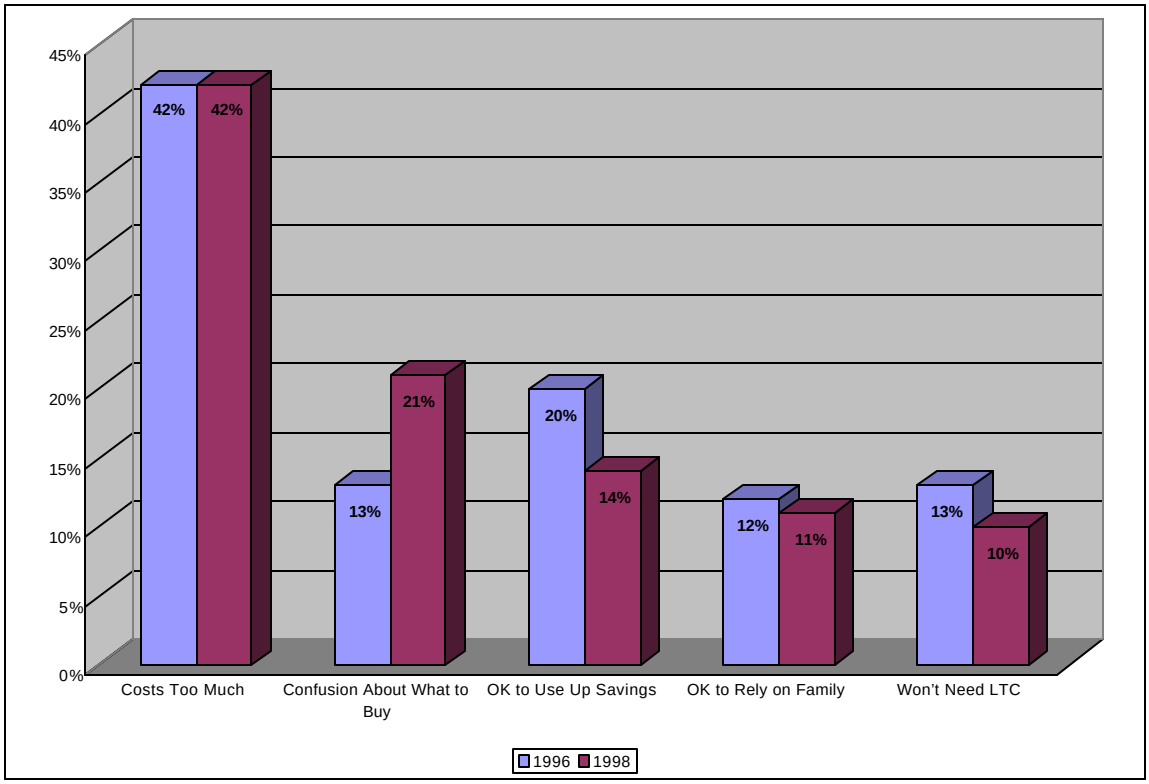


Source: Aggregate response to numerous surveys. Long-Term Care Group, Inc. 2001

Non-Buying Behavior

The reasons for not buying LTC insurance coverage have also varied (see Figure 3). CalPERS studies conducted in 1996 and 1998 show cost to be the main reason people do not buy coverage. Confusion about what to buy has increased slightly as a reason not to buy. A belief that care will not be needed is also cited as a reason not to buy. While non-buyers cite it is okay to use their savings to pay for care, this response has decreased from the 1996 to the 1998 survey. Stating the reliance on family as a reason why people do not buy changed little over the two studies.

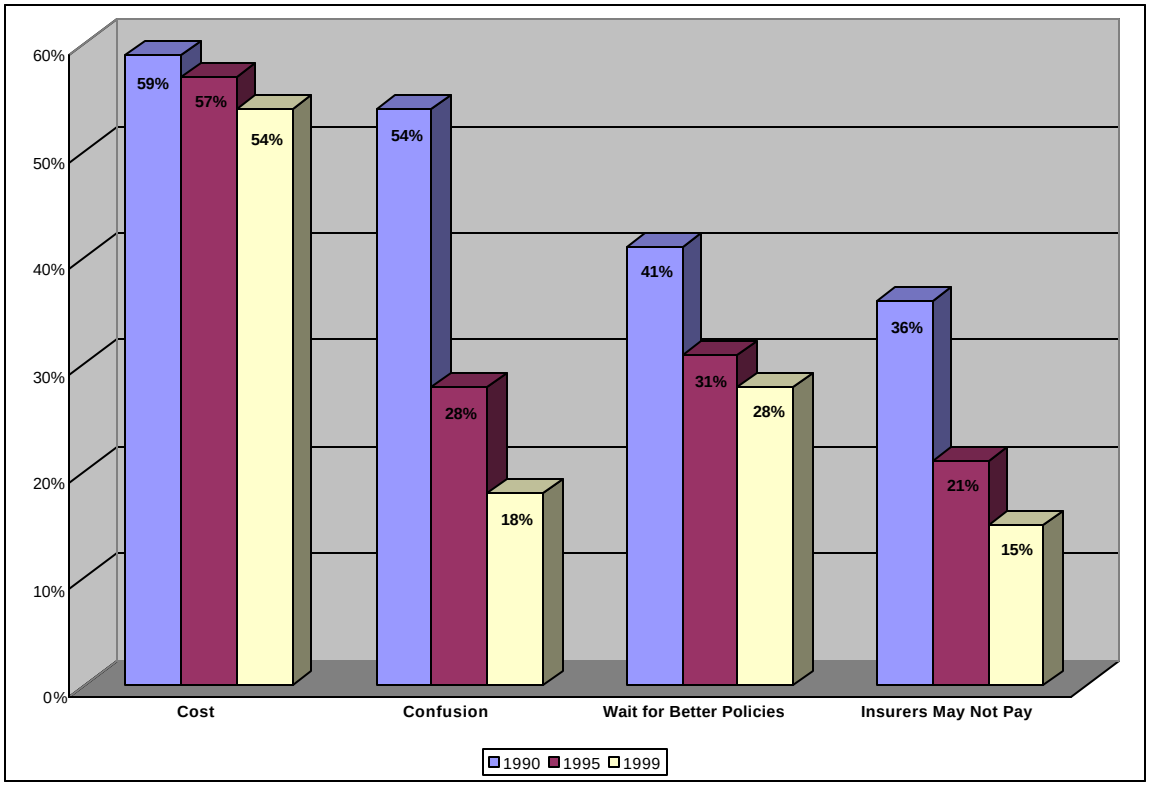
Figure 3. Reasons Not to Buy Long-Term Care Coverage, 1996 and 1998



Source: CalPERS Long-Term Care Program, 2001

Three studies conducted by HIAA cite similar reasons why people do not buy coverage for their LTC needs (see Figure 3). Cost and confusion remain the primary obstacles. Interestingly, lack of consumer confidence in LTC insurance products has diminished significantly as a reason not to buy coverage. This suggests that the enhanced consumer protection standards and more uniform coverage brought about by the Health Insurance Portability and Accountability Act (HIPAA) have bolstered consumer confidence in insurance as a planning option. Giving consumers more accurate information about the risks and costs of care and the affordability of coverage is also important.

Figure 4. Reasons Not to Buy Long-Term Care Insurance, 1990, 1995, and 1999



Source: Health Insurance Association of America, 1999

Affordability of Long Term Care Insurance

The percent of persons who currently have LTC insurance is quite small. While there is widespread agreement that fewer individuals have LTC insurance than could afford to buy coverage, there is no consensus on what proportion of today's seniors could afford coverage. This is due in part to the fact that affordability is not a purely objective concept. To some extent, affordability is in the eye of the beholder and depends upon one's financial situation, desire for insurance, attitudes about insurance, and family situation. While one person may be willing and able to spend only 3 percent of their income on a particular purchase, another person who has a higher level of need and desire for that purchase may be willing to spend 5 percent or more of their income.

As shown in Table 8 (below), estimates of the percent of seniors who could afford LTC insurance have ranged from as little as 2.3 percent to as high as 63 percent.[170] This wide range stems from the fact that previous studies have used a variety of assumptions about the portion of income that people are willing and able to spend on LTC insurance or the income and asset levels they must have before they would consider buying coverage.

[170] Cohen, MA. ,Kumar N, and Wallack SS., "New Perspectives on the Affordability of Long-term Care Insurance and Potential Market Size", *The Gerontologist*. Volume 33 (1), 1993

There are three major reasons that the literature shows such a wide range of estimates for the affordability of LTC insurance:

- **Policy Cost.** Estimates of affordability vary because there is no uniform definition of the design and cost of LTC coverage being purchased. One study might measure affordability against a "typical" policy type and cost, while another study might assess affordability based on an "ideal" policy. Thus, the cost to obtain LTC insurance could vary significantly from one study to another and have a significant impact on estimates of affordability, even where all else is held equal.

- **Income.** These various studies have also used different measures of income. Some have included the annuitized value of assets as "income" and other studies have excluded assets completely. Some have considered discretionary income and others have used total income.

- **Willingness to Pay**. Finally, studies must make assumptions about how much income (however measured) people will be willing to spend to buy a policy (however defined). Some studies assume a fixed amount (e.g., 5 percent or 7 percent) while others specify an amount that varies by age, income, or marital status. This approach tends to ignore the reality that willingness to pay also varies based on the perceived value of having coverage. (For instance, those who perceive the risk of needing LTC as "extremely likely" are willing to spend a greater portion of their income (8 percent) on insurance to protect against this risk than those who feel that their risk of needing care is "not very likely" (5.6 percent).) In reality, there is no one correct figure that should be used across all persons.

Table 8. Previous Studies on Estimating the Affordability of Long Term Care Insurance

Study	Criteria	Affordability Estimate
Meiners, 1983	Percent greater than Bureau of Labor Statistics hypothetical budgets.	18% of married couples 65+ 37% of single people 65+
Cohen, et. al., 1987	Willing to spend 10% to 25% of discretionary income.	10%-63% of married couples 65+ 33%-48% of single people 65+ 19%-57% of all people 65+
Rivlin & Wiener, 1988	Willing to spend 5% of income.	10%-21% of people 67+
Ball & Bethell, 1989	Premiums of $2,000/couple and assume only people with $50,000+ income can afford.	11% of elderly couples
Friedland, 1990	Various combinations of willingness to pay, insurance premiums and income and asset thresholds.	6% to 20%
Cohen et. al., 1991	Subjective purchase criteria based on industry input. Account for asset levels, health status, premium costs and presence of Medicaid.	50% of 65-74 years olds 38% of 75-84 year olds <10% of 85+ year olds Total potential 42%
Zedlewski & McBridge, 1993	Affordability thresholds of 2.5%, 5%, and 7.5% of income excluding assets.	2.3%-18.9% can afford; At 5% threshold, 12% of couples and 11% of people age 65-69

Source: Cohen, MA, Kumar, N, and Wallack, SS. "New Perspectives on the Affordability of Long-term Care Insurance and Potential Market Size." *The Gerontologist*. Volume 33 (1), 1993.

One study that attempts to shed some light on the affordability debate compiled data on the actual "willingness to spend" based on information about policy cost and income and assets from a national survey of nearly 8,500 people who had purchased LTC insurance.[171] The study looked at the percent of income being used to pay for coverage, whether or not assets were used in the purchase, and the adequacy of the coverage being purchased. One finding from this study was that using a "willingness to pay" criterion of 5 percent of income would exclude the more than one-third of current purchasers who are presently spending more than 5 percent of income on policies that provide adequate coverage. For example, among those with less than $20,000 in income, premiums represented from 4 percent to 12 percent of income. For those with incomes between $20,000 and $35,000, the portion of income used to buy coverage ranges from 2.2 percent to 6.6 percent. Across these income categories, the proportion of buyers in the highest "willingness to spend" category ranges from 13 percent to 27 percent of all buyers. Finally, the study indicated that between 60 percent and 70 percent of buyers do use some portion of their savings to pay for LTC insurance.

Table 9. Distribution of Percent of Income Used for Long Term Care Insurance

Income Category	Lowest % of Income Used	Highest % of Income Used
Under $20,000	4.0% (23%)	12% (13%)
$20,000 - $35,000	2.2% (18%)	6.6% (14%)
$35,000 - $50,000	1.4% (13%)	4.2% (17%)
Greater than $50,000	1.0% (9%)	3.0% (27%)

(The numbers in parentheses represent the proportion of all people in each income category that are represented by the "lowest" and "highest" percent of income used categories.)

Source: Cohen, MA, Kumar, N, and Wallack, SS. "New Perspectives on the Affordability of Long-term Care Insurance and Potential Market Size." *The Gerontologist*. Volume 33 (1), 1993.

So what is the most current estimate of affordability, based on these issues around income and insurability? The most recent estimates suggest that 25 percent to 35 percent of the senior market and 55 percent to 70 percent of the younger market (under 55) could afford coverage.[172] In the individual market today, there is a very pronounced trend toward younger buyers; over 35 percent of today's buyers are under age 65. When people buy coverage at younger ages, they have higher incomes and lower premiums, so the potential to afford coverage is greatly expanded. This trend toward younger buyers, coupled with the fact that policy costs relative to the value of coverage are declining, will further expand the potential market that can afford LTC coverage from where it is today.

Other Long-Term Care Options

Purchasing LTC insurance is by no means the only way of planning for future LTC needs. Alternative and supplementary financing options exists, as do housing choices. Some of these are discussed below.

[171] Cohen, et. al., 1993.
[172] LifePlans, Inc., 2001.

Home Modifications

According to a 2000 AARP study, entitled *Fixing to Stay*, 86 percent of individuals age 45 and over have made at least one simple modification to their home in order to make it easier for them to live there.[173] The study is the fourth in a series of surveys asking individuals about housing, home modifications, and their future plans for remaining in or moving from their residences.

As the authors of *Housing America's Seniors* point out, "the regular housing stock is not designed to meet the changing needs, tastes, and preferences of seniors as they age. As a result, the market for home modifications and health care and other supportive services to help older Americans live safely and comfortably in their homes is large and growing."[174] Given that 82 percent of seniors would prefer to be cared for within their homes rather than in an institutional setting, it is very likely that the home modifications market will continue to see significant growth.[175]

Research also suggests that home modifications would not only allow seniors to stay in their preferred setting, but also substantially decrease medical expenditures, a finding that may also contribute to growth in the modifications market. A recent study compared a group that received all the devices and home modifications that they needed with a control group that received only the services and equipment covered by Medicare and Medicaid. The initial expenditure for participants receiving the additional help averaged $2,233 per person; ultimately, the treatment group spent only $5,630 on nursing home care and hospitalization compared to $21,847 for the control group. Further, those provided assistance accounted for only $98 per person for in-home nursing and care manager visits, compared to $855 for the control group.[176]

Of the individuals who have modified their homes, 18 percent would like additional modifications. Table 10 provides a summary of the reasons why these individuals, as well as those who have never modified their homes, have not made modifications. Table 10 illustrates, a significant proportion of respondents indicated that a lack of information (e.g., about how to make changes, fund a contractor, or get information) has influenced their decision not to complete a home modification. These reasons have particular relevance to planning a comprehensive LTC campaign. Of course, it should be noted that several of the other reasons could also be addressed through an education campaign. For example, a campaign could provide information about government entities or non-profit organizations that provide home modifications at low or no cost to the homeowner.

[173] Bayer, et al., Fixing to Stay – a National Survey of Housing and Home Modification Issues, AARP, May 2000. Conducted by Greenwald and Associates, Inc. and National Research LLC.
[174] Schafer, R.A., "Housing America's Seniors." Joint Center for Housing Studies of Harvard University, 2000.
[175] Bayer, et. al., 2000.
[176] Retrieved from www.asaging.org/at/at-204/research3.htm on February 19, 2001.

Table 10. Reasons For Not Making Home Modifications

Reason for Not Making Modification	Major Reason (%)	Minor Reason (%)	Not A Reason (%)
Unable to do it himself/herself.	20	17	60
Cannot afford it.	18	18	61
Do not trust home contractors.	12	17	67
Do not know how to make the changes or modifications	9	16	72
Do not have anyone to do it for him or her.	9	14	74
Do not know how to find a good home contractor or company that does home modifications.	8	14	75
Think home modification features and products would not look nice in his/her home.	4	17	76
Do not know where to get information about modifying his/her home.	5	15	77
Cannot get to a hardware or home supply store.	2	10	85

Source: Bayer, et. al., 2000

From the above table, we can infer some of the information needs for people over age 45. However, the table below explicitly summarizes the percent of all respondents and of minority respondents that indicated they were either very interested or somewhat interested in receiving information about a particular topic. As the table illustrates, minorities expressed significantly greater interest in information about these issues than the general respondent population. Although not included within the table, it is interesting to note that interest also tended to vary by the age of the respondent. Interest in information about staying in one's own home as one gets older was equally important to all age groups, but, for all of the other topics, younger respondents expressed greater interest in receiving information.

Table 11. Information Needs of Survey Respondents

Issue Area	All Respondents (% Interested or Somewhat Interested)	Minorities (% Interested or Somewhat Interested)
Staying in your own home as you get older	52	63
Avoiding home repair or home modification fraud	32	47
Types of home modifications	28	44
Finding reliable home improvement contractors	21	42
Learning the facts about a reverse mortgage	20	40
Financing home modifications	17	39

Source: Bayer, et. al., 2000

As mentioned above, the vast majority of elderly have modified their homes in some way. Research indicates, however, that certain subgroups of the population are significantly less likely to have done so. For example, Tabbarah, et. al. find that, even when controlling for factors such as income and health, minority populations are less likely to have modifications such as grab

bars.[177] Tabbarah, et. al propose a few explanations for the discrepancy, including the "possibility that knowledge of home modifications may not be equal across ethnic groups."[178] Given the interest expressed by minority respondents in the AARP survey in receiving information about home modifications (Table 11), this seems like a viable explanation to account for at least some of the differences between the general elderly population and minority elderly.

Tabbarah, et. al., citing research completed by Fox also state that persons with severe disabilities are less likely than the persons with mild disabilities to have home modifications. As for the discrepancy between minorities and the general population, researchers believe this may be due to the fact that these populations are not as aware of the types of modification available.[179]

One way of better disseminating information about home modifications is through the local Area Agencies on Aging (AAAs). A recent study sought to determine whether AAAs recognize the importance of this issue and sought to educate seniors in their area about it. Researchers found that "about one-third (of AAAs) give a high-priority to improving access to assistive technology and home modifications services to elders in their service area. The same number feel their staff is adequately trained to address these issues, and one-quarter had assessed the need for such services in the past five years."[180] The fact that two-thirds of the agencies do not prioritize this issue may indicate that many AAAs may not understand the contribution that home modifications can make to seniors' ability to remain living at home. Given the access that AAAs have to elderly and disabled populations, partnering with AAAs and educating staff about home modifications may provide an effective method for increasing awareness about the availability of these options.

Since elderly populations cite an overwhelming preference for staying in their homes, the market for home modifications is expected to grow substantially, particularly as the baby boomers begin to retire and experience higher rates of disability. However, the general population and, especially, minority and disabled individuals, do not seem to have all the information that they need or want about these options. The LTC campaign should therefore include information about this topic in its educations efforts. Partnering with the AAAs to disseminate the information may be one strategy for doing so.

Reverse Mortgages

AARP reports that 51 percent of survey participants have heard of a reverse mortgage. "Of those who have, only one percent of homeowners have a reverse mortgage and six percent know someone who has one."[181] Minority respondents, however, were significantly less familiar with this option, as only 31 percent indicated that they had heard of a reverse mortgage. The survey also indicates that there is a cautious interest in the use of reverse mortgages, as 19 percent of

[177] According to Tabbarah, et. al, "Hispanics are about half as likely as White Non-Hispanics to have special railings, and African Americans are almost 40 percent less likely to have grab bars and shower seats."
[178] Tabbarah, M., "A Health and Demographic Profile of Non-Institutionalized Older Americans Residing in Environments with Home Modifications," *Journal of Aging and Health*: 12 (2) 204-228, May 2000.
[179] Ibid.
[180] Retrieved from www.asaging.org/at/at-185/atech-aaa.html on February 19, 2001.
[181] Bayer, et. al., 2000.

respondents might consider using one in the future. In addition, as indicated in Table 11 above, 20 percent of all respondents and 40 percent of minority respondents indicate that they would like to learn more about this option.

According to a 2000 Housing and Urban Development (HUD) report, 38,000 elderly homeowners were using the federal government's Home Equity Conversion Mortgage (HECM) program in October 1999.[182] The demographic characteristics of the HECM borrowers compared to the all elderly homeowners included:

- HECM borrowers tended to be older;
- HECM borrowers were more likely to be single female households;
- Properties tended to be more valuable and owners had a higher average equity share;
- Participants more often lived in the West and Northeast regions of the country; and
- Program participants were increasingly located in the center city.

The HUD report indicates that the program has been steadily growing and is expected to continue to do so. While researchers at the Harvard Joint Center for Housing Studies agree that the number of seniors using reverse mortgages will grow, they argue that the risk aversion of this population will mean that the expansion is "likely to be modest at best." In addition, the relatively low monthly payments available to many homeowners also provide an impediment to the growth of this option.

The HUD report research also included a series of focus groups in three cities to assess participants' satisfaction with the program, reasons for their initial interest, and suggestions for improvement. While the information gleaned from focus groups is not meant to be statistically significant, it does provide insight into the various reasons why seniors turn to this type of financial arrangement. Focus group participants indicated that they used the payments from their reverse mortgages in the following ways:

- To cushion their current income and help them pay living expenses;
- To finance home modifications, such as remodeling a bathroom;
- To provide supplemental income to cover miscellaneous expenses, such as travel; and
- To convert home equity assets into cash for investing.

While reverse mortgages seem unlikely to become a major part of long-term planning, experts agree that the number of users will continue to grow. Furthermore, given that a large number of individuals have not heard of this option, a campaign that includes information about reverse mortgages may increase consumer interest in them and the number of users.

Relocation

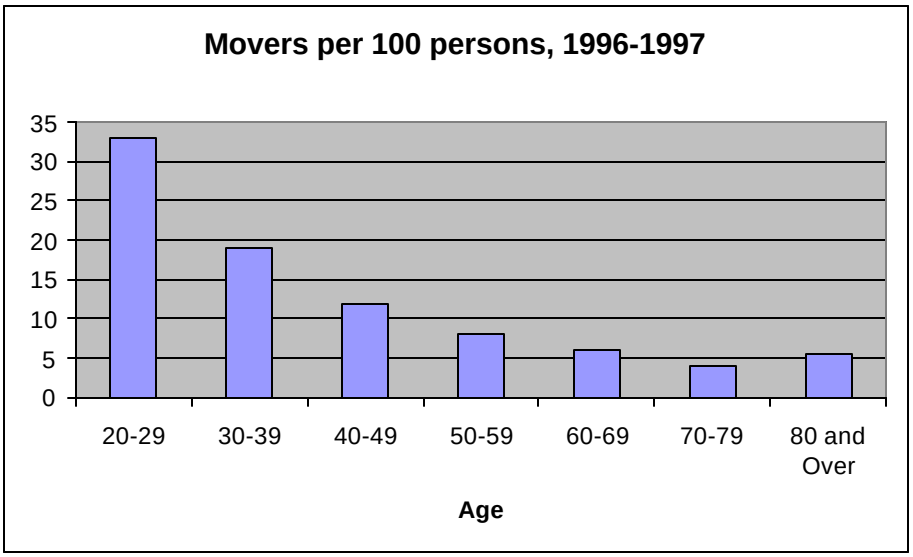
According to the AARP study, "Americans age 45 and over tend not to move frequently. Approximately three in five have lived in their current home for 11 or more years" (23 percent for 11 to 20 years, 17 percent for 21 to 30 years, and 19 percent for more than 30 years).

[182] Evaluation Report of the FHA Home Equity Conversion Mortgage Program, 2000.

Furthermore, the study shows that the respondents do not want to move, with 83 percent of respondents strongly or somewhat agreeing that they want to stay in their current residence for as long as they can. Older age groups indicate an even stronger desire to remain in their homes. Survey respondent not only *want* to stay in their homes, but also tend to believe that they *will* stay in their homes, as sixty-three percent believe that they will always live in their current residence.[183]

Despite their reticence to move, 39 percent of those 60 and over change residences, although more than 80 percent of these moves are local.[184] The chart below shows the annual moving rates by age in the U.S.

Figure 5. Movers Per 100 Persons, 1996-1997



Source: Joint Center for Housing Studies of Harvard University, Tabulations of the 1997 Current Population Survey as published in *Housing America's Seniors*.

Furthermore, contrary to the popular belief that the elderly often make a long-distance move after retirement, very few, including recent retirees, make interstate moves. While Florida, Texas, and other states do have a large number of elderly migrants, the overall percentage of elderly individuals moving out of state is only one percent per year. A study from the Harvard University Joint Center on Housing points out that this percentage actually over-represents true interstate migration since many of these moves are across state lines but within the same metropolitan area.[185]

There are, however, some states that will experience a significant increase or decrease in the proportion of their population over age 65 due to in-migration or out-migration. The following

[183] In the 1989 survey, 24 percent of respondents had made plans, while in the 1992 and 1996 28 percent had done so. (Bayer, et. al, AARP, Fixing to Stay, 2000).
[184] Schafer, 2000.
[185] Ibid.

table summarizes those states that will experience significantly higher growth in their elderly populations by the year 2025.

Table 12. National Growth Trends - Elderly Populations

Substantially Leading National Growth Trend	Substantially Lagging National Growth Trend
Alaska, Arizona, Colorado, Georgia, Idaho, Montana, New Mexico, Nevada, North Carolina, Oregon, South Carolina, Texas, Utah, Washington, Wyoming	Connecticut, District of Columbia, Illinois, Massachusetts, Michigan, New Jersey, New York, Ohio, Pennsylvania, Rhode Island

Source: Schafer, et al. *Housing America's Seniors*, 2000.

Litwak and Longino provide an explanation of elderly relocation patterns based on developmental stages and support needs.[186] They categorize these moves as follows:

- First move: The first type of move is often linked to retirement, as elderly look to move to amenity-rich locations. These movers tend to be younger, healthier, wealthier, and married.
- Second move: This move is often linked to the development of chronic disability that makes it difficult for an individual to live independently. These movers are older and often widowed and move to areas where they can access support, usually near adult children.
- Third move: The final type occurs when disability has worsened to the point where informal care and family support is no longer enough to meet the needs of the individual. These movers experience significantly increased levels of disability. These moves are often local, as the individuals often move from conventional housing into institutional settings.

In testing their model, Litwak and Longino analyzed the demographic data of those moving from Northern states to Florida (assumed to be movers in the first group) and those moving from Florida to Northern states (assumed to be movers in the second group). They found that about 15 percent of those moving to Florida are over age 75, but over 40 percent of those moving North are over 75. In addition, disability and institutionalization rates are, respectively, two and a half and nearly ten times higher for those moving from Florida than those moving to Florida.

Information from the AARP study, which was completed more recently, seems to also support these models. The information indicates that relocations for the young elderly are not often spurred by LTC considerations, whereas moves by older age groups more frequently are. The fact that young elderly are not making their decisions about where to live based on their LTC needs does not necessarily mean that they are not thinking about those needs at all, only that these are not yet the priority. Given the competing interests of those who are at pre-retirement age, it may make sense to target aspects of the LTC education campaign to those who are on the verge of and have just begun to fully consider their LTC needs.

[186] Litwak and Longino, "Migration Patterns Among the Elderly: A Developmental Perspective." *The Gerontologist* 27 (3): 266-272, 1987.

Medicaid Estate Planning

Experts disagree about the extent to which people use Medicaid estate planning techniques to protect their assets and qualify for Medicaid. As Joshua Weiner from the Urban Institute writes:

> *Perhaps no other policy issue in long-term care has generated as much heated debate as the practice of some middle- and upper-class elderly persons transferring their assets to relatives or others in order to qualify for Medicaid. . . (Some) observers estimate as much as $5 billion a year – roughly 20 percent of Medicaid nursing home expenditures – could be saved by reducing what is often referred to as 'Medicaid estate planning.'*[187]

The author continues that it is difficult to determine the number of individuals engaging in these practices, however, research suggests that it is significantly less than often assumed. Weiner cites the fact that the disabled elderly often have few assets and, therefore, little incentive to protect those by transferring them. In addition, he points out that if the number of elderly transferring resources was, in fact, increasing, one would expect a corresponding increase in the number of Medicaid nursing home residents, which has not occurred.

While the number of individuals using Medicaid estate planning is contestable, the fact remains that some individuals do engage in these practices. A recent study, conducted by Curry, et. al., sought to determine the incentives and disincentives of individuals for using Medicaid estate planning to cover the cost of LTC services. Findings from a series of focus groups are listed within Table 13 below. [188] Although Curry, et. al. find that Medicaid stigma is a disincentive, this finding is not universal nor is Medicaid necessarily equated with welfare.[189]

Table 13. Incentives and Disincentives for Using Medicaid Estate Planning

Incentives	Disincentives
♦ Preservation of estate ♦ Protection of community-dwelling spouse	♦ Loss of control of assets ♦ Medicaid stigma: self-esteem and quality of care issues ♦ Morality

Source: Curry, et. al., "Medicaid Estate Planning: Perceptions of Morality and Necessity," *The Gerontologist* 41(1): 34-42, 2001.

Medicaid estate planning issues have garnered a great deal of attention, as the popular press has often run stories about the use of elder law attorneys to shelter the assets of the wealthy and upper middle dass to take advantage of Medicaid benefits. In an effort to prevent this, Congress enacted several pieces of legislation over the last decade to make asset transfers to qualify for

[187] Weiner, J. "Reducing Medicaid Spending on Long-Term Care." Retrieved from www.urban.org/periodcl/26_2/prr26_2e.htm on February 23, 2001.
[188] Curry, et. al., "Medicaid Estate Planning: Perceptions of Morality and Necessity," *The Gerontologist* 41(1): 34-42, 2001.
[189] Fabrizio, McLaughlin, & Associates, Secure Research Program on behalf of the American Health Care Association, March 1998.

Medicaid illegal.[190] Because these laws make these practices subject to both criminal and civil penalties, some experts expect a significant decrease in the number of persons using Medicaid estate planning. In addition to decreasing Medicaid expenditures, researchers believe that these laws will also encourage middle- and upper-class elderly to purchase LTC insurance rather than risk the loss of their assets due to the cost of nursing homes and other LTC services.[191]

[190] Ahmad, O. "Medicaid Eligibility Rules for the Elderly Long-Term Care Applicant: History and Developments 1965 – 1998." *Journal of Legal Medicine*: 20 (2), June 1999.

[191] Gordon, H. "Why Don't They Buy; Don't Blame Planners." *McKnight's Long Term Care News*: 62, January 1997.

IMPLICATIONS FOR A LONG-TERM CARE AWARENESS CAMPAIGN

In general, there is a lack of awareness and understanding of what LTC is, the risks of needing LTC, the costs of care, and who pays for the care when needed. Many Americans do not want to think about needing LTC and, therefore, fail to plan for it. Others wrongly assume that Medicare or standard health insurance policies will cover the costs of LTC services. Denial, negative impressions of LTC, and fear of becoming a burden to one's children are other major obstacles for people in considering LTC options and planning.

Pervasive deficits in awareness and understanding about LTC and the need to plan, in addition to negative attitudes about LTC demonstrate the need for public education on these issue. Existing literature suggests the following implications for a LTC consumer awareness campaign:

- It is necessary to create a common language around LTC. Before anything else, the target population needs to understand what LTC is and why it is important. Because of the high level of negativity surrounding LTC, the issues need to be framed carefully, in quality-of-life and life-enhancing terms. It is also important to address the fact that LTC not about a particular set of services (i.e., nursing home care) but is about fostering "functional wellness."
- One significant gap in knowledge that a public education campaign can address is the fact that most people do not know how their care would be paid for if they need it, or they erroneously think Medicare or an employer pension plan would cover it.
- It is important to educate the family unit. LTC is a "family affair," although discussions about planning for LTC are often difficult to broach. A campaign can support these discussions and empower the friends and family (including adult children) that are important sources of information to individuals that need care now or may need it in the near future.
- Campaign messages can potentially be built on the reasons that compel people to buy LTC insurance (a visible form of planning). Two of the most frequently cited reasons for buying include the preservation of savings and the desire to lessen burdens on family members.
- Campaign messages may be more salient for certain groups. For example, older people and women tend to have a greater awareness of LTC issues and may be more receptive to messages or more prone to act than younger people or men. Younger adults in caregiving roles may also be more difficult than other groups to reach -- at least about their own LTC plans.
- If the campaign desires to effect behavior change, messages should be empowering so as to increase feelings of self-efficacy among consumers. Messages may (depending on consumer testing and project goals) focus on models of "functional wellness" and manageable steps to achieving this state.

It should be noted that the majority of research on consumers' attitudes, understanding, and planning behavior around LTC has been conducted by the insurance industry. While there is much to gained from this research, the literature on social marketing and health communications emphasizes the need for further qualitative and quantitative consumer research to better understand the target population.

APPENDIX: MARKETING TO THE HISPANIC/LATINO POPULATION

Introduction

The Hispanic/Latino population is a unique segment of the general population that merits special attention when building a national public awareness campaign. This population has received little attention about LTC from the media and has a different set of values than mainstream America. Both language and culture should be considered when crafting effective messages for this audience.

When targeting the Hispanic/Latino community, it is important to recognize that this is a heterogeneous population, as Spanish-speaking families have emigrated from several different countries with unique cultures. In general, however, research shows very little segmentation, but focuses on the commonalities of this population. There are three basic beliefs that pervade Hispanic/Latino cultures:

- Familiasim - Respect for elders is valued and it is usually the responsibility of the children to care for their aging parents. Also, family members stray neither geographically or emotionally.
- Personalism - A collectivist mentality prevails, with emphasis on the group over the individual. Personal relationships are cultivated with time, based on friendship, loyalty, trust, and respect.
- Spiritualism – Hispanics/Latinos generally place a high regard on spirituality, prayer, and faith. Often, these beliefs manifest themselves in fatalism.

Barents' recent research on the communications needs of the Hispanic/Latino populations found that most Hispanic/Latino individuals prefer to receive health care messages in Spanish. According to a recent study by *People En Espanol*, [192], 83 percent of the Hispanic/Latino population speaks Spanish as the dominant language in the home, and 95 percent access Spanish-language media. Even of those Hispanic/Latinos living in the U.S. that are proficiently bilingual, 88.6 percent speak Spanish as the predominant language and prefer to receive messages in Spanish. Research has also shown that materials should be developed in a "neutral" Spanish that would be understood by all dialects and persons from all region. (An exception would be if you are targeting a particular area where the population is predominantly homogeneous, for example, Cuban-American.)

Messages

Messages targeting Hispanic/Latino populations should incorporate the themes of familiasm, personalism, and spiritualism. One way to approach a message would be to place an emphasis on family relationships. It is not the effect upon the individual, but rather the effect upon the family unit that may prompt a response within Hispanics/Latinos. For example, studies have found that

[192] *People En Espanol* commissioned NuStats International to conduct the second annual Hispanic/Latino Opinion Tracker (HOT Study), for which NuStats interviewed over 1,400 self-identified Hispanic/Latinos in 2000.

when deciding to cease smoking, Hispanics/Latinos were generally motivated by the repercussions to their family over the detriment to individual health.[193] Similarly, when disseminating planning messages, focusing on the benefits to the family, such as financial security, emotional and physical relief, and maintaining quality relationships, may resonate with this group. Conversely, a message that focuses on personal choice, comfort, or independence may not be motivating.

Another way to design a message may be around relationships. Personal relationships are built upon trust and common respect. Hispanics/Latinos, therefore, may respond to messages that evoke a sense of reciprocity in the relationship. A more personal approach offers a sense of care on a human level. For example, J.C. Penney used the slogan "Te queda bien" – J.C. Penney fits you well – which compliments the consumer as being engaged in the relationship.[194] The message is positive and emphasizes the relationship over the intended product. Similarly, in discussing long-term care, personalizing the planning message may be helpful in reaching this audience.

Respect for both elders and authority would also be beneficial to a communications campaign. Using elder Hispanics/Latinos as spokespeople could be well-received.[195] Research also indicates that messages from "official sources" resonate with the Hispanic/Latino population. For example, messages from the Surgeon General were considered important because of his credibility and trustworthiness as both a government official and a professional from the medical community.[196]

Venues

Community-based organizations. Because of the importance of personal relationships to Hispanics/Latinos, community-based organizations, churches, and leaders within the Hispanic/Latino community are important partners to consider when delivering messages. Research by Barents Group has found that local health clinics, neighborhood businesses, community centers, and home health agencies are also effective messengers in communicating health information to the Hispanic/Latino population.[197]

Family networks. In targeting Hispanics/Latinos, not only is it effective to draw upon family themes, but also to inform family members and friends, who can be important catalysts for information. For example, many Hispanics/Latinos are accompanied by their family on outings,

[193] Perea A; Slater M. "Power distance and collectivist/individualist strategies in alcohol warnings: Effects by gender and ethnicity." *Journal of Health Communication.* Oct-Dec 1999;4(4):295-310.
[194] Zipkin, A. "Retailers up the ante; Top chains buy upfront, expand ad offerings to entice Hispanic/Latinos." *Advertising Age*. Sep 18, 2000;S18-21.
[195] Gonzales, A. "Growing Latino market remains 'untapped'." *Sacramento Business Journal*. July 14, 2000;17(18):27-30.
[196] Perea, Slater, Oct-Dec 1999.
[197] Barents Group, *Resources for Reaching Out: Medicare Savings for Qualified Beneficiaries*. CD-ROM. Baltimore, MD: Health Care Financing Administration.

such as doctors' visits[198] - one way to reach this population might be to provide information in the waiting areas. Another example would be to distribute messages through workplaces or during television programming that younger family members may watch.[199]

Radio. Radio is an effective way to reach Hispanic/Latino populations. Hispanic/Latino radio stations contend for top ratings in Los Angeles, Miami, and New York. This medium may captivate the Spanish-speaking illiterate population, as well as those bilinguals that prefer to receive health messages in Spanish. It also reaches both rural and urban populations. However, communications experts warn against a straight translation of material from English into Spanish, observing that content and overall messages need to be crafted into Spanish language and be culture-appropriate.[200]

Magazines. *People en Espanol* reported that found 76 percent of Hispanics/Latinos read magazines. Of those, 70 percent are Spanish-language magazines. Three of the largest Spanish-language magazines in the United States are *Ser Padres*, *Una Nueva Vida*, and *Embarazo* (Vaughn 2001). Another venue may be *Nuestra Gente* ("Our People"), a quarterly publication published by Sears with a circulation of 800,000.[201]

Direct Mail. Direct mail is a virtually untapped area for reaching Hispanics/Latinos. While the average U.S. Hispanic/Latino household only receives 20 pieces of direct mail per year, the average Caucasian household receives 300 pieces. For this reason, this population appears to be more responsive to direct mail.[202]

Internet. According to *Hispanic/Latino Business* magazine, studies show that the Hispanic/Latino population prefers Internet sites in English.[203]

[198] Ross J. "Hispanic/Latino Americans: Who are they, where are they, and how do we talk to them?" *Hospitals & Health Networks.* Dec 20, 1995;69(19)65-8.
[199] Barents Group, *HCFA Market Research for Beneficiaries: Summary Report on the Hispanic/Latino Medicare Population*. Baltimore, MD: Health Care Financing Administration, April 1999
[200] Gonzales, July, 2000.
[201] Zipkin, September 2000.
[202] Yorgey, LA. "The Latino Renaissance." *Target Marketing*. Dec 1, 2000;23(12):40-46.
[203] Romney, L. "QuePasa becomes first big Latino 'dot-com' flop." *Los Angeles Times.* Dec 28, 2000;C1.