Sharing Increasing Costs on Declining Income: The Visible Dilemma of the Invisible Aged

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ODAY, THE FEDERAL GOVERNMENT PROVIDES AN estimated $50 billion in benefits and services to the 6 million people who are very old (80 years of age and over). These are more benefits than are given for all of the nonaged poor; it is also twice what is spent today for total veterans benefits or unemployment benefits in the United States. And as the size of this age group grows disproportionately to the rest of the aged, their total benefits will increase faster than for any other beneficiary group.

Even though the very old are one of the most important federal beneficiary groups today, little information about their specific income benefits and economic resources is known. The federal government considers the aged a single beneficiary group of people 65 years of age and over, and data collectors consider them a single cohort. As a result the very old are virtually invisible to policy makers, program managers, and the public.

Before World War II the people 65 years of age and over were a very small beneficiary and cohort group, and therefore, summary statistics on the aged were appropriate. But since World War II the number of people 65 years of age and over has more than doubled and life expectancy at age 65 years has increased 23 percent. Consequently, today the aged are not only the largest single group of

federal beneficiaries, but they are also more diverse economically than the nonaged. Our information about them, however, has lagged behind their growing importance. While health statistics have recognized the importance of information about specific groups among the aged, the information about nonhealth federal benefits for the aged usually aggregates information about the elderly. And economic data about them is almost always provided for the aged as a whole rather than for age groups among the elderly. Yet, when the federal benefits and economic data for the aged are disaggregated, they describe a situation that is much more complex than the summary statistics suggest.

This paper describes how the federal costs for the aged increase with age and how the costs for the very old are estimated to grow disproportionately in the future. The paper then briefly describes recent proposals to share some of the costs of federal benefits and the effects of such proposals given the distribution of income and assets among the aged. And finally, it discusses the problems of sharing the costs for the very old between generations.

The Federal Costs of the Very Old

The major federal benefits of the aged increase significantly as they age. As shown in table 1, major federal benefits for the person who is 80 years of age and over are an estimated 16 percent more than for the person who is recently aged (65 to 69 years of age). This is the net result of larger medical and long-term care benefits offset by smaller Social Security benefits for the very old than for the newly aged.

The estimation of these federal benefits for the aged by age group in 1984 is an aggregation of what information exists about the age distribution of Medicare, Social Security, and long-term care benefits. These estimates of federal benefits aggregate all benefits for those 80 years of age and over because that was the oldest age group used in the Medicare history sample in 1978 from which the Medicare information is derived. Because of the lack of federal data by age, however, the estimated aggregate and per capita federal benefits provided aged beneficiaries are more illustrative than definitive. But estimates suggest how important it is to understand better what happens to federal benefits, both as beneficiaries age and as succeeding cohorts of the aged age.

TABLE 1
Major Federal Benefits for the Aged in 1984

Age of beneficiary	Population* (in thousands)	Per capita benefits (in dollars)					
		Medicare**			Social Security*** (OASI)	Federal cost of long-term care (LTC)****	Total OASI, HI, SMI, and LTC
		HI	SMI	Sub-total			
65 to 69	9,095	885	517	1,402	5,689	60	7,151
70 to 74	7,501	995	559	1,554	5,568	60	7,182
75 to 79	5,409	1,238	592	1,830	5,425	262	7,517
80 years and older	5,980	1,781	704	2,485	4,972	864	8,321

Sources: * U.S. Bureau of the Census. 1984.
** Medicare history sample: average Medicare reimbursement for 1978 converted to 1984 dollars.
*** *Social Security Bulletin. Annual Statistical Supplement* 1983. 1982 benefits adjusted by increase in CPI to estimate 1984 benefits.
**** The federal per capita cost of long-term care is based on the probability of needing the care and age-specific costs as described in U.S. Public Health Service 1983.

The Medicare benefit estimates for each age group in table 1 are from the Medicare history sample for 1978. They were adjusted by the medical consumer price index (CPI) to approximate the benefits in 1984 dollars. As can be seen in table 1, people aged 80 and over receive, on average, 77 percent more Medicare benefits than the younger old. Eighty-three percent of the increase in Medicare benefits between the young and old elderly is because of the increase in hospital insurance (HI) benefits; the supplementary medical insurance (SMI) benefit, which pays some of the outpatient health costs, increases relatively little as a person ages.

Social Security estimates of benefits by age are for specific categories of beneficiaries. The estimates shown in table 1 are for average benefits for retirees, who are the largest group of aged Social Security beneficiaries. The per capita benefits, however, are somewhat higher than the average benefits for other Social Security beneficiaries who include dependents and survivors. Average Social Security benefits for the very old retirees are 13 percent less, relative to the newly retired. In general, the newly retired have a higher real wage history than older retirees. Since the wage history is the basis of the calculation of the primary Social Security annuity, the higher wage histories of the newly old result in higher benefits than those received by the very old.

The federal benefits that increase the most as a person ages are those for long-term care. These estimates are also the most speculative since the calculation of total federal long-term care benefits are based on a number of assumptions. The long-term care estimates in table 1 include benefits provided primarily by Medicaid and the Veterans Administration. They do not include the long-term care benefits that are provided by Medicare since those benefits have already been included in the estimates of Medicare benefits by age group. They also do not include the long-term care benefits provided by the states through matching Medicaid payments for the aged. However, the state Medicaid benefits for long-term care are substantial and should be included in any study that goes beyond the focus of this paper on federal benefits.

The estimated federal long-term care costs are distributed among the aged by the 1983 probability that each age group was in a long-term care facility. Rough estimates of the annual per capita federal cost of long-term care not covered by Medicare in 1984 range from $60 for every person aged 65 to 74 to $864 for each person aged 80 and over. While these numbers are not large on a per capita basis

because most aged never use long-term care, the costs for the average 5 percent of the aged who annually actually require long-term care are, of course, considerably larger than the per capita numbers shown in table 1.

Federal health and long-term care benefits increase 129 percent between the youngest and oldest cohorts of the elderly. But this increase is substantially offset by the decrease in the per capita Social Security benefits between the two cohorts. When the estimated per capita benefits for Medicare, Social Security, and long-term care are added together by age group, the total per capita benefit for the very old is only 16 percent higher than the benefit for the newly retired in 1984. This difference in the per capita benefits between the young aged and the very old is quite modest. When that difference is multiplied by the difference in the future rate of growth between the different age groups, however, the fiscal implications become more serious.

Between 1984 and the year 2000 the total number of aged is expected to increase 25 percent. And the ratio of the aged to the potential work force, which is a measure of the aged-dependency burden, is likely to increase only 12 percent. These aggregate numbers, however, mask the aging of the aged cohort themselves and, therefore, tend to underestimate the potential size of future federal benefits.

By the year 2000 the group aged 65 to 69 will be virtually the same size as it is today, compared to a 66 percent increase in people 80 years of age and older. This growth of the group aged 80 and older, combined with their somewhat larger per capita benefits, will increase the total cost for this group rapidly. The aging of the aged population, however, will not increase health costs proportionately. Much of the increase in health costs for the older age groups can be attributed to the high cost of dying in the United States. If the life expectancy of the aged increases in the future as now projected, dying will occur at later ages than today (U.S. Bureau of the Census 1984). Therefore, the high costs of dying in the future will occur in older cohorts than it does today (Fuchs 1984). And utilization of health services at younger ages may also decline (Manton 1982).

Simply to illustrate the potential importance of the future growth in the very old federal beneficiaries, however, cost estimates are presented in table 2 that assume that the real per capita costs of the major federal benefits remain the same in the future for the age cohorts of

TABLE 2

Effects of Population Changes Alone on Major Federal Benefits for the Aged, by Age Groups for 1984, 1990, 1995, and 2000* (population in thousands; benefits in billions of 1984 dollars)

Age group	1984		1990		1995		2000	
	Popu-lation	Total benefits	Popu-lation	Total benefits	Popu-lation	Total benefits	Popu-lation	Total benefits
65 to 69	9,095	65.0	9,996	71.5	9,736	69.6	9,096	65.0
70 to 74	7,501	53.9	8,039	57.7	8,767	63.0	8,581	61.6
75 to 79	5,409	40.7	6,260	47.1	6,640	49.9	7,295	54.8
80 years and older	5,980	49.8	7,402	61.6	8,745	72.8	9,949	82.8
Total	27,985	209.4	31,697	237.9	33,888	253.3	34,921	264.2

* Assumes 1984 average annual per capita Social Security, Medicare, and long-term care benefits.

beneficiaries. These estimates probably overestimate future health costs for the reasons stated above. They also probably underestimate total federal costs because they do not include a number of other federal benefits for the aged such as civil service and military retirement, supplementary security income, and food stamps since disaggregated age-specific data are not readily available for these benefits. However, we do know that virtually all of the aged receive federal benefits of some kind. Therefore, the estimates in table 2 assume that all of the aged in each age cohort receive the average per capita benefits presented in table 1 even though we know that some receive considerably more and others less. This assumption, however, allows us to begin estimating how the aging of federal aged beneficiaries will affect federal benefits in the future. These estimates will be improved considerably when better program data become available and when better estimates can be made of health costs for future aged cohorts.

If we assume that the average real per capita federal benefits remain the same in the future, then by 1990 the federal government will be paying $12 billion more (in 1984 dollars) than today, solely because of the increase in the number of people aged 80 and older. By 1995 the increase will be $23 billion and by 2000 it will be $33 billion more than today, as shown in table 2. The 66 percent real increase in estimated federal benefits provided to people aged 80 and older in the next 15 years is twice the increase for any other subgroup of the aged population. By the year 2000, total benefits for the very old will be larger than any other subgroup of the aged or, for that matter, the general population.

These population projections assume that mortality rate improvements will continue in the future, but not as rapidly as in the last 15 years (U.S. Bureau of the Census 1984). If mortality rate improvements do continue as rapidly as in the last 15 years, there will be 700,000 more people aged 80 and older in the year 2000 than are presently estimated. This would then increase the estimates of total federal benefits for this group 7 percent more than is suggested in table 2.

The estimates of major federal benefits by age groups in the future are not definitive because the data are inadequate for precise estimates. But the changes in the magnitudes of the total benefit and the benefits by cohorts are suggestive of how the aging of the aged will affect federal programs. These projections reinforce the results of other projections that federal health benefits for the aged in particular are likely

to increase substantially in the future. And all of the projections raise issues about how the costs for these future benefits should be paid. One of the most important issues is whether the beneficiaries should share part of the costs of their future benefits.

Cost-control Proposals

The Medicare program is estimated to begin running large deficits within the next 10 years according to program actuaries and analysts (Palmer and Torrey 1984). These deficits will be largely the result of the increase in the number of the aged, the aging of the aged population, and the increase in medical costs as a person ages. Some proposals to reduce or eliminate the pending deficits focus on constraining the cost of medical care, the income of the providers, or the provision of services. Other proposals suggest new kinds of insurance coverage, such as for long-term care. Still other proposals focus on sharing the federal costs more directly with the beneficiaries, their families, or their estates. These latter cost-sharing proposals raise the issues of what economic resources the aged and their families have and how well they could, in fact, share their costs. More specifically, these proposals raise the issues of whether the aged who have the most costs are those that have the individual or family resources to share them.

Proposals to share Medicare costs with the beneficiaries do so by proposing to increase their deductible, coinsurance, or premiums. These proposals are not only expected to decrease federal outlays as private out-of-pocket costs for the aged increase, but also to increase the incentives of the aged to use Medicare benefits more efficiently. Several of these cost-sharing proposals include means-test provisions so that the aged who could not afford the increased costs would not have to bear them (Meyer 1984; Davis and Rowland 1984). However, in order to understand how these proposals would affect the aged, we must know not only the distribution of costs among the aged, but also the distribution of their income.

The Income of the Very Old

A number of recent studies suggest that the income of the aged on average is, at least on a per capita basis, comparable to the income

of the nonaged (Hurd and Shoven 1985; Danziger et al. 1984). Since the aged, however, represent people spanning 35 years in age, a single income average does not adequately describe their heterogeneity. While good data exists on the income of the aged in general, most cross-sectional surveys such as the Current Population Survey or the Survey of Income Program Participation do not have sample sizes that are statistically reliable for the very old. And longitudinal surveys such as the Retirement History Survey have not yet followed a significant number of the retired into very old age. The 1980 decennial census is the only source of statistically reliable information available on the income of the very old. The census contains extensive data for age cohorts within the aged and for the institutionalized population. People who are institutionalized for whatever reason—sickness, mental disorders, or convenience—are usually ignored by other surveys because of the sampling and measurement problems.

The decennial census is, of course, a cross-sectional survey; therefore, the economic behavior of a single cohort over time cannot be determined from it. Also, for all age groups, income data from the census are generally biased downwards. And it is probable that the data on the elderly are more biased than data for the younger population because the elderly tend to underreport their money income considerably more than the nonaged (Radnor 1981). The underreporting of income is the result of both underestimating the amount of income received and underreporting whether the income is received at all. If under-reporting is directly related to age among the aged, then it may mean that the differences in income among the young and the older aged are somewhat less than the census data shown in table 3 suggest. Despite these problems with the decennial census, the data are adequate for discussing the ability of the very old today to share their increasing medical costs.

As shown in table 3, the average income of people aged 85 and older is 36 percent less than the income of people aged 65 to 69. This difference is largely the result of lower earned income as labor-force participation drops 74 percent between the two cohorts and the lower average Social Security benefits of older retirees. Table 3 also records a comparison of the age-specific income of different groups among the aged, such as unmarried men and women and couples. Some of these groups overlap, of course; the disaggregation of the average income, however, suggests which groups among the aged are most important in determining the income trends among the cohorts.

TABLE 3
1980 Average Income of the Aged

Category of aged	All ages	65 to 69 years	70 to 74 years	75 to 79 years	80 to 84 years	85 years and over	Percentage difference in average total income between 65 to 69 years of age and 85 years of age and older
Population (in thousands)	25,517	8,784	6,816	4,789	2,930	2,197	—
Average income:							
Total aged	7,505	8,621	7,534	6,923	6,381	5,540	−36%
Aged men	10,245	11,993	10,029	8,986	8,256	7,212	−40
Aged women	5,535	5,756	5,631	5,557	5,339	4,748	−18
Aged couples	15,476	17,458	15,018	13,676	12,810	11,723	−33
Unmarried men	7,545	8,641	7,605	7,183	6,865	6,338	−27
Unmarried women	6,123	7,023	6,462	5,996	5,536	4,803	−32
Poor couples	5,702	5,697	5,736	5,712	5,669	5,596	−02
Poor unmarried men	3,722	4,147	3,679	3,519	3,509	3,405	−09
Poor unmarried women	2,672	2,720	2,723	2,683	2,628	2,513	−08
Institutionalized	3,563	3,464	3,484	3,647	3,701	3,493	+01

Source: U.S. Bureau of the Census, The 1980 Decennial Census, unpublished tabulations from the 5-percent public use microdata sample.

Aged men in general and couples in particular experience the biggest difference in income from ages 65 to 69 years to 85 years and older; these are the two groups that were most likely to be in the labor force in the cohort aged 65 to 69 and, therefore, experience a greater decline in income as they age and leave the labor force. The smallest income difference is among the poor aged. Since the level of poverty benefits is the same regardless of age, the poor may appear to be more homogeneous across aged cohorts than the nonpoor aged.

The income of the institutionalized is actually larger for the oldest cohorts relative to the newly old cohorts. This suggests that the people in institutions who are very old may have a considerably different economic history than the institutionalized aged who are younger. It also may be the result of measurement and response problems since many of the institutionalized do not receive their income directly, and, therefore, may not accurately estimate the level of income that is provided for them.

When the differences in medical costs by age groups among the aged are compared with the differences in income among the same age groups, the dilemma of sharing Medicare costs becomes clearer. As income declines 36 percent between ages 65 to 69 years and 85 years and older, Medicare costs increase 77 percent between ages 65 to 69 years and 80 years and older. In 1984 people 80 years of age and older received an estimated $2,485 in benefits from Medicare, which is almost one-third of the average income they received. If, for example, new cost-sharing provisions required that 20 percent of present Medicare benefits were paid by the beneficiary, it would result in an average $500 a year increase in cost for the very old and a $3 billion savings to the federal government because of their cost-sharing. It would, however, decrease the income of the very old by 8 percent. If the cost-sharing was income-tested, then much less than the $3 billion would be saved by the federal government because the very old as a group have so little income.

The distribution of income among the aged and the role public transfers have played in modifying the distribution are important issues not addressed in this paper. This paper also does not discuss the dramatic drop in poverty rates among the aged in the last 20 years, largely due to the growth in public income and in-kind benefits. These topics are fully discussed, however, by G. Lawrence Atkins (1985).

Assets of the Very Old

Ironically, the very old, who have the highest health costs, may have considerably more assets than income. The Medicaid program, which provides most of the federal long-term care benefits to the aged, recently recognized this possibility by allowing states to attach a lien to the estates of the aged who receive long-term care benefits from Medicaid. When the beneficiaries die, their estates can then be used to defray the costs of their long-term care. In order to address the issue of assets, however, we need to know more than we do now about the distribution of assets among the aged.

Although the very old are one of the most important federal beneficiary groups, almost nothing is known about the distribution of their assets or how they spend them. The life-cycle hypothesis suggests that people will save enough while they are working so they can maintain their consumption after retirement by dissaving (Modigliani 1980). In other words, people would build up their assets during their working years, and then, when they retire and their income declines, spend their savings. Before the recent tax reforms there was also a strong incentive to give wealth to heirs while still alive to avoid the estate taxes. Unfortunately, whether the aged do dissave for whatever reason cannot be determined yet because of insufficient data.

There are two recent sources of information on the assets of the aged, the 1979 Survey of Income and Program Participation (SIPP) and the Retirement History Survey (RHS). A third source of information is the Federal Reserve Board's Survey of Consumer Finances. All three surveys, however, do not adequately sample the very old and therefore no significant data exists on the assets of this group.

Recent analysis of SIPP data has made the first attempt to show assets by different cohorts of the aged. The SIPP data has the same underreporting problems described for the 1980 decennial census. There are substantial nonresponses to asset-value questions, and financial assets appear to have the highest percentage of underreporting (Radnor 1984). Nevertheless, all respondents said they had some form of assets, which is a higher response than in the Retirement History Survey.

As shown in table 4 the same percentage of people 75 years of age and older have assets as those 65 years of age and older. The net worth of the assets, however, is 22 percent more for the group aged 65 and older than for the older subgroup. More than half of the

TABLE 4

Average Amounts of Assets, and Percentage Holding Each Type of Asset,
1979*

	Age of householder	
Type of asset	Total, 65 years and older	Total, 75 years and older
AVERAGE AMOUNTS		
Net Worth	79,390	65,030
Wealth	79,930	65,530
Home equity	25,110	19,480
Financial assets	28,020	28,610
Liquid	8,020	7,560
Nonliquid	20,000	21,040
Business equity	5,660	3,400
Other assets	14,090	8,640
Durable goods	7,060	5,410
Unsecured debt	540	500
PERCENTAGE HOLDING EACH ASSET		
Net Worth	100%	100%
Wealth	99	100
Home equity	66	59
Financial assets	95	96
Liquid	95	96
Nonliquid	36	31
Business equity	4	3
Other assets	18	16
Durable goods	98	99
Unsecured debt	39	28

Source: 1979 Survey of Income and Program Participation: Second and Fifth Waves.
As presented in a paper titled "The Wealth and Income of Aged Households," by
Daniel B. Radnor, presented at the American Statistical Association meeting, Phil-
adelphia, August 1984.
* All estimates are preliminary. Dollar amounts are rounded to the nearest $10.

difference can be explained by the difference in home equity and
durable goods. Financial assets are actually slightly higher for the
older cohort of aged than for all those aged 65 years of age and older.

Recent studies based on the longitudinal Retirement History Survey
(RHS) avoid the problems of interpreting cross-sectional data and
provide insights into how a single cohort of newly aged people behave
over time. Burtless and Moffitt (1984) found that the real wealth of

the RHS respondents declined somewhat between 1969 and 1979 even though real home equity grew. Friedman's (1982) study of a subset of the same data base suggests that the aged reduced their consumption in the first 6 years after retirement and continued to save, but then dissaved afterwards. Using the same data, Hammermesh (1983) confirms the reduction in consumption in the early years of retirement, and Merrill (1984) confirms the growth in home equity over time.

But the Retirement History Survey, which is the basis for these studies, is describing the economic behavior of a cohort as they approach and enter retirement. The initial RHS interviews were made in 1969 of 11,000 respondents who were then between the ages of 58 and 63. By 1979 these respondents were between 68 and 73 years of age; therefore, the assets of a cohort as it becomes very old has yet to be described.

While the SIPP and RHS clues are useful, none of them are definitive enough yet to conclude how many assets the very old have and what they do with their assets. Both studies, however, suggest that the aged may have substantial assets. One recent proposal was to have the final Medicare contribution paid after a beneficiary's death (Long and Smeeding 1984). The contribution could be made from a limited portion of the decedent's estate to pay for the Medicare benefits received that were in excess of previous contributions to the program. The final payment would have to be limited to a fraction of the estate after both spouses die. Since many estates of the aged may be considerable, the proposal would provide significant revenue without reducing the economic security of the beneficiaries while they are alive. The reduction of the estate, however, would affect the heirs directly, although it could be argued that the negative income effects of such a proposal on the heirs would be partially offset by a slower rise in their social insurance taxes than would be necessary without an estate contribution.

Historically, the families of the aged, not the federal government, have been expected to bear the major burden of their support. In 1965, the federal government paid for only 15 percent of the health care of the aged (Fisher 1980). With the advent of Medicare benefits, the burden of support for elderly parents was increasingly shared with the federal government, which today provides approximately half of the medical benefits of the aged. A final Medicare contribution from the decedents' estates, in effect, would be a contribution from the

heirs that would begin to return some of the responsibility of health costs of the aged to the families. Again, however, if the effects of the proposal are examined with respect to the very old in particular, instead of the aged in general, the issues become somewhat more complex.

Intergenerational Cost-sharing

The age of the children of the elderly will, in part, determine how feasible it is for them to increase their future responsibilities for their parents either through direct contributions or estate contributions. The children of the younger aged are, in general, 20 to 35 years younger than their parents and, therefore, are in the middle of their working years, near the peak of their earning power. While they also have financial responsibilities for children and mortgages, they, in general, are likely to have substantial resources. The children of the very old, however, are themselves either aged or approaching retirement, when their income is expected to decrease significantly. As table 5 records, the median age of the children of women who are 85 years

TABLE 5
Median Age of the Children of 85-year-old Women*

Year in which mother is 85 years of age	Year in which mother was born	Age of mother after having half her children	Median age of child when mother is 85 years of age
1980	1895	26.7	58
1985	1900	26.1	59
1990	1905	25.9	59
1995	1910	26.8	58
2000	1915	27.4	58
2005	1920	27.2	58
2010	1925	26.7	58
2015	1930	25.8	59
2020	1935	24.7	60

Source: Fertility tables for birth cohorts by color, U.S. 1916–73, *Vital Statistics of the U.S.*, Vol. 1, *Natality*.
* These estimates assume similar mortality rates of mothers and nonmothers and of children regardless of their cohort.

of age in 1985 is 59 years. And this median age of the children stays remarkably constant for 85-year-old women until the mothers of the baby boom, who had their children at early ages, retire.

The children of the very old are, in general, considerably older than the children of the newly old. As a consequence, the ability of the children of the very old to share the increasing costs of their parents may differ significantly from the ability of the children of the younger aged. Much more needs to be learned about how much the children of the very old today do provide in financial and housing support to their parents, relative to the children of the newly old. And these differences will be important to address in any proposals for intergenerational cost-sharing.

Conclusion

Since 1960 considerable federal resources have shifted from children to the aged (Preston 1984). This shift paralleled the change in the relative size of each group. This reallocation of resources is likely to be repeated among the aged themselves in the next 15 years. As the very old become the largest group among the aged, more resources are likely to be used by them than by other age groups.

Already, the federal per capita cost of the very old is demonstrably larger than for the rest of the aged, and the increase of these costs relative to other benefits to the aged is inevitable. Little attention, however, has focused on the needs and resources of the very old. They are almost invisible economically because they are statistically small.

The aged as a group are very diverse, not only as federal beneficiaries but also as economic units. But the limited economic and beneficiary statistics we have been using to describe the aged have helped to mask the diversity among them. Longitudinal surveys, such as the Retirement History Survey, allow us to estimate not only income and assets at one point in time for different groups among the aged, but even more important, to see also how people behave economically as they age. Even though each cohort may age differently, the insights from such a survey would be invaluable.

Even a series of cross-sectional surveys would be helpful in determining the present distribution of economic resources among the subgroups of the aged. But reliable surveys require considerably larger sample

sizes for the very old than are now used. And increasing sample sizes costs money. Yet, until we have more disaggregated data, we will continue to treat the aged as a homogenous group. And the very old will continue to be statistical ghosts who leave only a few clues to their benefits, needs, and economic resources.

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