DOCUMENT RESUME

ED 056 269 AC 012 007

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TITLE The Sciences and Aging. Adding to the Knowledge about Aging.
INSTITUTION Kentucky Commission on Aging.; Kentucky Gerontological Society.; Kentucky Univ., Lexington.
and application of industrialization programs are examined.
PUB DATE 11 Nov 71ek-long conference on early childhood education. Th
NOTE 39p.; Paper presented at Seminar on The Sciences and Aging, University of Kentucky, November 11, 1971

EDRS PRICE MF-$0.65 HC-$3.29
DESCRIPTORS *Adult Counseling; *Geriatrics; *Human Services; *Older Adults; Personnel Needs; Research; *Social Problems

ABSTRACT

The Social Sciences, as they relate to the aged and the aging, are discussed. Social gerontology seeks to discover the role of the social environment as a determinant of aging and of the behavior and position of older people in society. In the United States, some 20 million people are over 65 years of age, and the median age of the elderly has risen to age 73. There are suggestions that there may be a direct relationship between successful adjustment in old age and educational attainment. It is estimated that about one-sixth of the elderly are functionally illiterate and only five percent are college graduates. It is believed that the solutions to the complex problems in gerontology will require the application of research techniques of practically every scientific discipline. A program in Cleveland, Ohio, utilizes retirees as "Gatekeepers" who act as liaison between health personnel and the elderly in the neighborhood. Communities need to offer a variety of alternatives to match the variety of individual needs among our aged and aging population. Services should include prevention, early diagnosis, and treatment of health problems, and rehabilitation services. Each individual should be offered education tailored to his needs. (DB)

Seminar: The Sciences And Aging
Adding to the Knowledge About Aging
University of Kentucky - November 11, 1971
W. Dean Mason, Ed.D.

Have you become weary of the words - "the last of life for which the first was made?" These words are oft times quoted in an effort to give positive emphasis to the aging process.

Gina Berriault [1] writing in the May 1971 issue of Esquire painted a rather graphic picture of our aged and aging citizens in an article titled, The Last of Life. I almost closed the magazine when I saw the title of the article but I read the small print underneath and then wanted to read further because -- it said that this was an introduction to a brand-new species, suddenly mutated, that must be reckoned with, kept separate and observed. My God! I thought is that what we are doing today in our concern for older persons? The more I thought about this the more guilt I felt because somehow we were (or I was) or might be viewing these twenty million members of a new minority group as objects to be reckoned with, kept separate and observed. Let us evaluate our actions - past, present and projected in light of such an attitude or motivational principal.

Said Berriault:

> "The old are the most deprived of all groups - economically, to name only one kind of deprivation - and at the bottom of this heap are the Aged Blacks, more than familiar with discrimination and want. The White Elderly get used to these things a little later in life. In Immense settlements of thousands, the Old live in mobile homes that are not going anywhere. Counties are erecting low-rent hhusing, though the choise is given to the residents around the selected site as to whether or not to permit such congregations. Is it a brand-new species, suddenly mutated, that must be reckoned with in all its characteristics, kept separate, observed, provided for? These numbers seem to have taken everybody by surprise, even as old age has taken them by surprise, even as most spectacular problems seem to errupt, but almost never do, without warning. Councils - regional, national, churchly, are now functioning at several universities, and one university in Los Angeles will have soon, if it does not already by now, a six and a half million dollar research and educational center. In Baltimore is a four and a half million dollar center for the study of the physiology and biology of aging, with hospital and laboratories.

Conferences are constantly called, of Mayor's Committees, a Coordinating Councils, and the 8th International Gerontology Congress was held at year ago (1970) in Washington, D.C., to which twenty-one nations dispatched three throusand delegates. (Another such Congress is scheduled to be held July 2 - 8, 1971 in Kiev, Russia.)

I find myself agreeing with a statement made by Dr. Robert J. Havighurst and the Special Committee on Human Development of the University of Chicago in the status report of Research and Applied Social Gerontology published by the Gerontological Society in the Winter of 1969.(2) This Committee said, "Old age in America may represent for many the triumph of technique over purpose." During the last 70 years we have seen many changes in medical care, food production and distribution, income distribution, housing patterns, and labor-saving machinery which have contributed to longer life for many more people. The prospect of old age [redacted] for many Americans has come about without much thought being given to what old age should be or what it might be in our American culture. If for most older people old age is a time when energy is low, the circle of family and friends diminish, and income reduced, what is to be expected as the reasonable hope for life satisfaction in the years past 65?

It is true that for most Americans old age is a time when the arenas of choice become constricted, the environment narrows, and functional decrements press more and more with each passing year. Social Gerontologists are trying to determine what the older persons' role is once his family-rearing and economically productive years are past. These are problems which we will be dealing with today.

We are concerned with the social sciences as they relate to gerontology. In other words, we might identify our thinking this morning as specifically social gerontology. Dr. Clark Tibbitts, in the Preface of the Handbook of Social Gerontology, which he edited in 1960 states that "Students working in a number of fields became aware, more or less simultaneously, of age or time as a variable to be reckoned with in the study of organisms and their

performance. This led, in turn, to interest in the life cycle of organisms and of human individuals and to the scientific study of aging itself." (3)

The sudden and explosive increase in the number and proportion of older people in the populations of all highly developed countries added importance to the increased interests in the study of the aging and aged. Thus these two factors, population and technological and socioeconomic change operating together resulted in separating large numbers of older people from the social roles traditionally assigned to adults and in raising them almost at once to the status of what we sometimes refer to as a "problem" group.

Social gerontology separates the phenomena of aging which are related to man as a member of the social group and of society and those phonemena which are relevant to aging in the nature and function of the social system or society itself. As we think of aging in the individual, social gerontology deals with changes in the circumstances, status, roles and positions which come with age, with the influence of age-related biological and psychological factors on the individual's performance and behavior in society and with his personal and social adjustment to the events and processes of aging. Socially, the study of aging is concerned with changes in the age composition and structure of populations, with the elements in the value system and institutional patterns which have a bearing on the status and roles of older people, with the effects of these factors and of technological and social change on older people, and reciprocally, the influence of older people on the values, institutions, and organizations of society.

Dr. Donald P. Kent, Pennsylvania State University, has suggested that, "the influences and inter-relatedness of the biological and social worlds of man have been well documented; but perhaps are no better illustrated than by viewing the social position and behavior of older persons." (4)

Aging is known to be a biological property of all living things. Although social structures are rooted in biological capacities in every society, these capacities permit, except in the cases of the very young and very feeble,

a variety of social patterns. The biological and social worlds are intertwined. As I understand it, the Kentucky Gerontological Society last year, was primarily concerned with the biological sciences.[5] This year we are to turn our attention to the Social Sciences as they relate to the aged and the aging.

Clark Tibbitts has suggested that "systematic approaches to the study of aging are of relatively recent origin, beginning with research on biological and psychological aspects, followed by studies of behaviorial and social science phenomena."[6] The biological research on aging has developed only within the past generation or two and the first real contribution came about not primarily as previously planned studies on aging, but as the life of plant and animals were being investigated.

The evolution of psychological research on aging seems to have taken on pretty much the same pattern. Oscar Kaplan, (1946) states that, although, "interest in the psychological aspects of aging goes back at least several thousand years, ... it is only within the last decades that comparative studies of adult age groups have put such interests on a scientific basis.[7]

Research on aging in the social sciences seems to have sprung from several developments which occurred within a relatively short span of time. Older people became visibly evident and the total population began to become concerned about this new segment of society. In 1946 Lawrence Frank in an article in the Journal of Gerontology enumerated a large number of social and economic problems needing study. Mr. Frank pointed out that in the last analysis aging is a problem of social science. He was unable to report on the existence of any significant amount of social research or any attempts to outline or systematize the fields, as he indicated that the biologists were doing.[8]

In 1943, Dr. E. W. Burgess who was serving as Chariman of the Social Science Research Council's Committee on Social Adjustment, secured the establishment of a committee on Social Adjustment in Old Age. This Committee published a research planning report which did call attention to the need for research in individual adjustment to aging and retirement; old age and the family; aging, employment, and income maintenance;

and aging in relation to other institutions. Burgess and Havighurst and their Associates initiated their studies of personal and social adjustments in old age and the Committee on Human Developments gave specific focus to the periods of later maturity in 1949.

Eight sections of the first National Conference on Aging held in 1950, were devoted to social, economic, and related aspects of aging, and all of these sections urged the need for research.

Leonard D. Cain, Jr. in a review of the book "Gerontology, A Book Of Readings" by Clyde B. Vedder, says, in commenting on a Volume of Readings in Gerontology, "This new and burgeoning field represents a peculiar amalgam of scientific research and a reformist commitment with the attributes of a major social movement. Gerontology is more than a discipline devoted to understanding phenomena and institutional adaptations to varying percentages and problems of the aging; it is also a crusade to help the older person lead a 'full life'." (9)

I agree with Clark Tibbitts and June Shmelzer who said in the February 1965 issue of Welfare in Review, "The umbrella we glibly call 'aging' does indeed include both a discipline and a practice. It embraces both a growing body of information about older people and a wide variety of programs, techniques, and institutional forms and adaptation developed in their behalf. Aging thus connotes both action and research, which, perhaps not uniquely, have been growing simultaneously." (10)

With respect to aging research the field has been divided into two broad categories which include the biological and social aspects. Each of these divisions can be broken down into a number of relatively clear-cut areas. Biological gerontology is concerned with normal aging in the human organisms, with particular reference to changes in tissue structure and function; in speed, strength, and endurance of the neuromuscular system; and in processes which may hasten normal aging and the long term diseases

and conditions common among older people. Social gerontology is concerned with the alterations in psychological capacities and performances, and with changes in the social characteristics, circumstances, status, and roles of individuals over the second half of the life span; with the nature and processes of adjustment, personality, and mental health in the aging individual; and with the biological processes of aging and changing health status insofar as they influence social capacities and performance in the later years. Social gerontology also seeks to discover the role of the social envionment as a determant of aging and of the behavior and position of older people in society. It is recognized by most persons engaged in the field that many, if not most of the problems we face, whether of research or application require a multi-disciplinary approach. This makes our gathering today very exciting as we have here a number of "sciences" seeking to discover their inter-relatedness in a concern for aged persons.

Those of us who are concerned with aging and aged persons and the participation of this group in our society are thinking about the future in order that our involvement in work related to gerontology and geriatrics will show that we have given thought to the future realizing that many of today's decisions will rest on conjectures about the future. We see problems that exist today and project ahead to conceived needs and thus make an effort to develop strategy which will give hope for a successful tomorrow. It may be that we will conceive of "alternative futures". We are told that we can look forward to a virtual "revolution" in the way people will live, the way they will work and they way they will play by the year 1980 and 1990. We are beginning to see revolutionary changes in the social structure which has a direct bearing on the older adult population. Some of our problems will be congestion, financial security, boredom from excessive leasure, the gap between the rich and the poor, environmental decay, housing, health and a redefining of roles for all age groups.

What are the prospects for the 70's? The next decade will be a prosperous one so we are told by students of businesss. We are assured that there will be technological advance and the discovery of answers to many

of our present day questions through research. This we will hope for - we will work for answers to poverty, sickness, war and all forms of human misery. The Council on Trends and Perspective Economic Analysis and Study Group of the United States Chamber of Commerce states in a document, America's Next 30 Years - Business and The Future, that there has emerged a new type of organization known as the "look out" institution which looks ahead into the future and seeks to plan for change by anticipating in advance. Such organizations are the Institute for the Future, General Electric Tempo and the Commission on the Year 2000. (11)

I would like to share some thoughts concerning our future environment. The world population in thirty years is expected todouble its present figure. This would mean that we would have seven billion people in the world. We may have 266 million people in America by 1982 and 325 million by 2000. By 1985 we could have 165 persons for every 100 we have today. Although we will have many more persons over 65 years of age, we are rapidly moving in the direction of a national population in which half of our people will be under 26 years of age. It is intersting to note that the rising tide of education has helped transform America from an economy of goods into a knowledge economy. We are told that by the late 1970's the United Sates "knowledge industries" (which produce and distribute ideas and information rather than goods) will account for one-half of the total U.S. national product. Every other dollar earned and spent in the American economy will be earned by producing and distributing ideas and information. A process of continuous learning (life-long learning) re-training and on the job education, post-graduate education will be accepted and considered necessary.

The next ten years are expected to bring large and significant changes in our Nation's system for meeting the health care needs of the total population. We find many problems upon us today in this area, with spiraling costs, maldistribution of personnel and facilities, and many varied opinions as to the solutions.

You might be interested in the fact that at the beginning of this decade there were 740,000 general hospital beds and that to maintain the present bed - population ratio we will have to add only11,000 beds per year by 1980 but we are actually adding 20,000 beds. There were 685,000, mental hospital beds and we need to add 10,000 beds a year by 1980 to keep pace with population growth. This figure will probably drop because of modern programming and out patient services.

There were 37,000 tuberculosis hospital beds at the turn of the century. This figure will decrease because of modern discoveries. There were 400,000 beds in extended care facilities. This area of service is expanding and improving rapidly. It is estimated that there should be a ratio of three beds per 1000 population. The current ratio is about two per 1000. According to this suggestion there should be an increase of 600,000 beds and by 1980 a projected need of 720,000 beds. I would like to mention here that during the past two decades the Hill-Burton program of federal assistance has helped more than 3,400 communities build hospitals, nursing homes and other health care centers. These programs have helped provide 350,000 hospital and nursing home beds. (12)

The Future ? Todays Generation of Oldsters Say Let's Deal With Facts! Todays FACTS - - - -

"The psychiatrist was interviewing a troubled patient. As the man unburdened himself, the psychiatrist suddenly said, "Mr. Smith, I want you to quit smoking."
"You do"? responded the anxious patient. "Would that help me?"
"Well, I really don't know," replied the doctor, "but you are burning a hole in my couch."

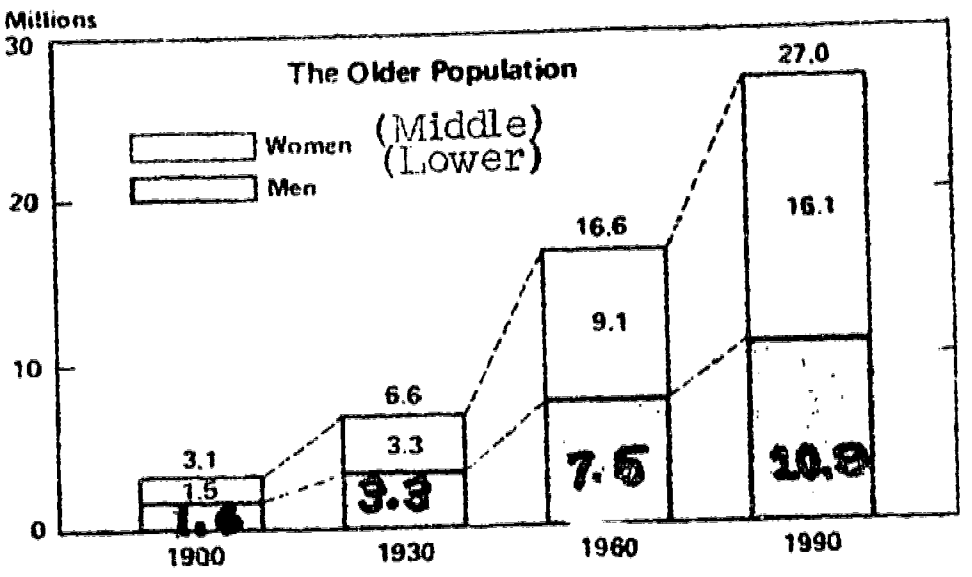
FACTS ABOUT OLDER AMERICANS

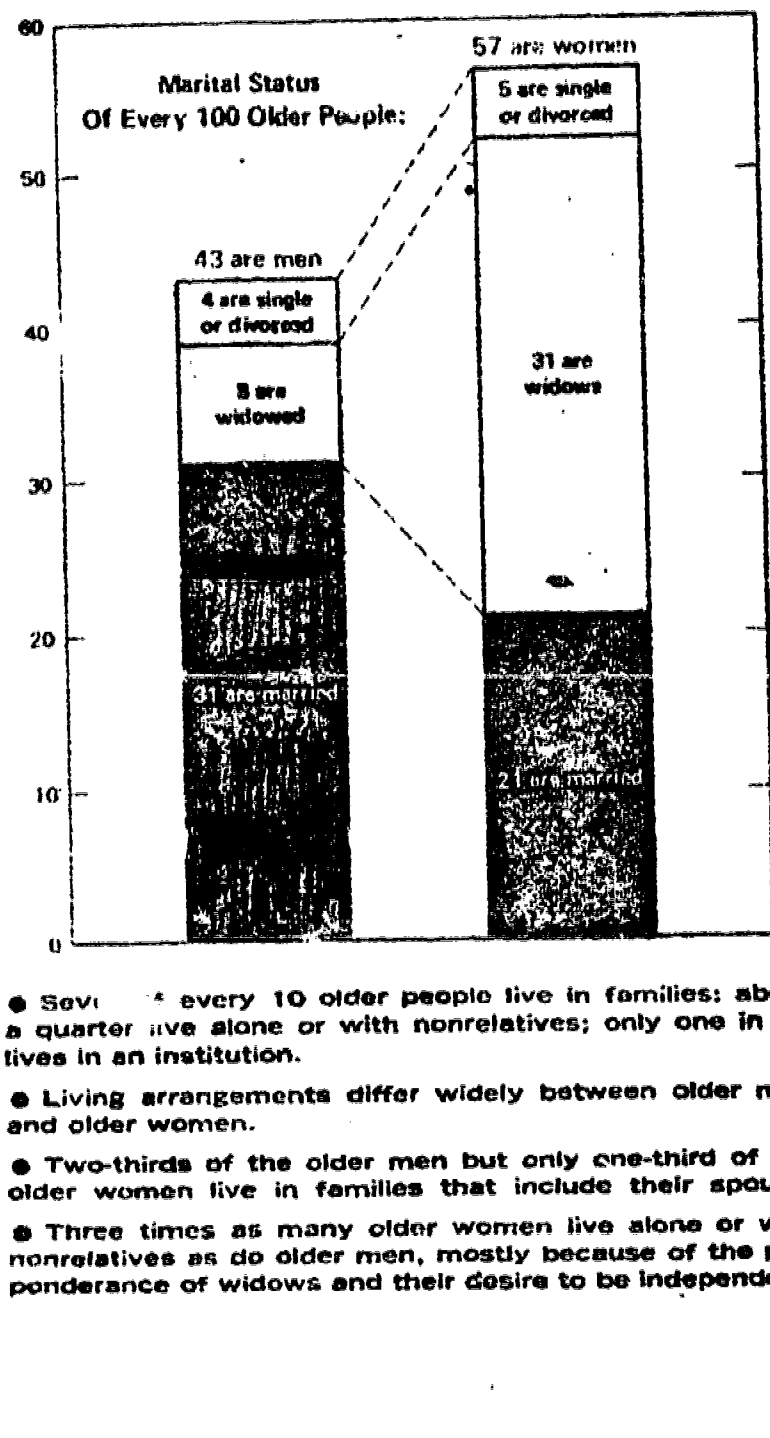
● Every tenth person in the U. S. is aged 65 or over — a total of almost 20 million men and women.

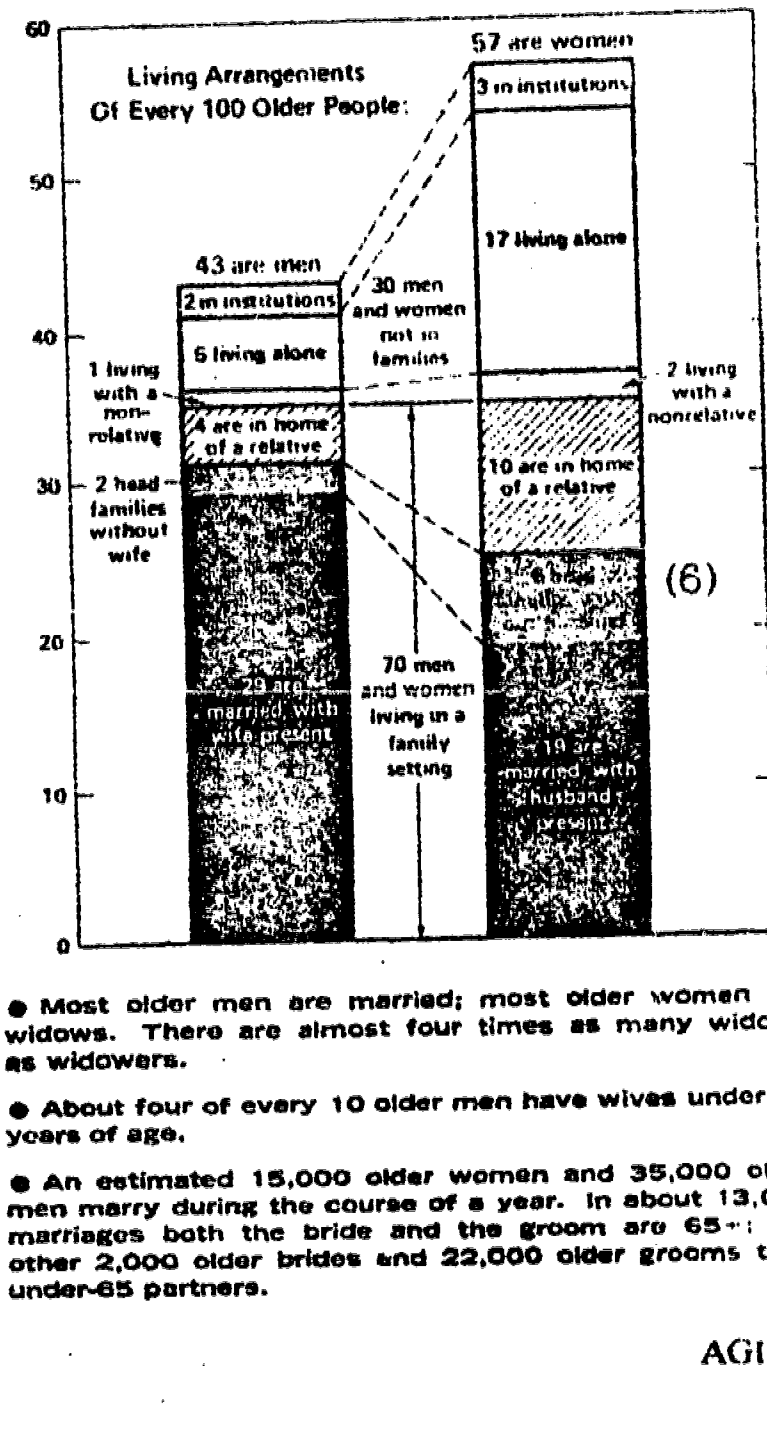
● This number exceeds by a million the total population of the 20 smallest States.

● In this century, so far, the percentage of the U. S. population aged 65 and over more than doubled (from 4.1% in 1900 to 9.5% in 1968), while the number increased more than six-fold (from 3 million to more than 19 million).

● Women now outlive men. There are about 134 older women per 100 older men. Life expectancy at birth is 73.8 years for females and 66.7 years for males. Life expectancy for women is still increasing faster than for men.







● Seven of every 10 older people live in families; about a quarter live alone or with nonrelatives; only one in 25 lives in an institution.

● Living arrangements differ widely between older men and older women.

● Two-thirds of the older men but only one-third of the older women live in families that include their spouse.

● Three times as many older women live alone or with nonrelatives as do older men, mostly because of the preponderance of widows and their desire to be independent.

● Most older men are married; most older women are widows. There are almost four times as many widows as widowers.

● About four of every 10 older men have wives under 65 years of age.

● An estimated 15,000 older women and 35,000 older men marry during the course of a year. In about 13,000 marriages both the bride and the groom are 65+; the other 2,000 older brides and 22,000 older grooms take under-65 partners.

It might be well for us to have an overview of the statistical dimensions of our aging population plus some insight into the exceedingly very human factors behind these statistics. It may be that we will be able to clear up some of the misconceptions about our older population and to challenge some of the stereotypes which society seems to have. There are many problem areas involved in the field of gerontology and they do tend to be somewhat unique to the age in which we now live. We have all heard the statistical data about the number of our aged persons and the increasing numbers of older people - those over 65. The fact that at the turn of the century every twenty-fifth American was 65 years of age or older while today every tenth American is 65 years of age or over. Therefore, we find in our present population some 20 million people over 65 years of age, a number which is equivalent to the toal population of our 20 smallest states.

Within this older population, the age distribution is as follows:

Age	Number	Percent
65+ ..	20,000,000	100.00
65-74.	12,280,000	61.4
75-84.	6,400,000	32.0
85+..	1,320,000	6.6

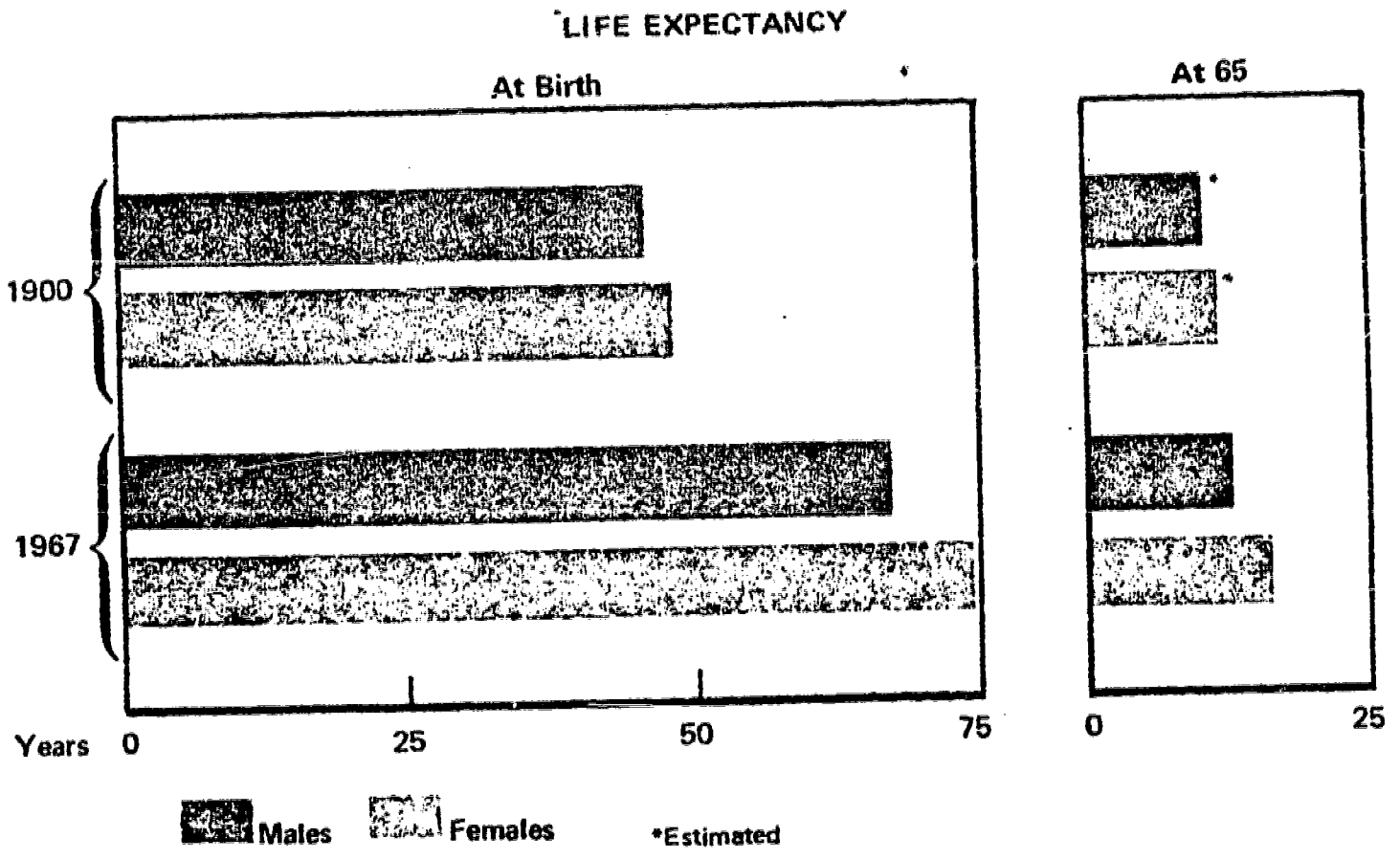
For every 100 persons in the "productive" age span of ages 18 to 64 there are only 17 older persons. Even greater significance, in view of the age range from just 65 to over 100 or a span of at least 35 years, is the enormous diversity within this population, representing a complete spectrum of characteristics and, thus, needs.

Moreover, the older population is not static; it is marked by rapid turnover. At the end of this year, about seven percent of the people aged 65+ will have joined this age group during the year. When the 1971 White House Conference on Aging convenes, about 70% of the age group under discussion will have become part of the older population after the close of the last White House Conference in 1961. These new comers are quite different from the group they replace.

In our present society the oldest part of the older population is growing the fastest so that the median age of the elderly has risen slowly to age 73. Four of every 10 older people or 8 million are 75 years of age and older. Better than one million are over 85 years of age. More than one-third or 7 million are under 70 years of age. We are told that each day some 4,100 Americans will celebrate their 65th birthday while 3,200 persons over 65 years of age will die which leaves a net increase each day of 900 older persons.

	Annual	Daily
Gross increase (number celebrating 65th birthday) .	1,480,000	4,100
Gross decrease (deaths of persons 65+)	1,150,000	3,200
Net increase (increase in 65+ population)	330,000	900

The numbers of the very old or those over 75 will continue to increase at about twice the rate of the over 65 group as a whole and at more than twice the rate of the total population. Today life expectancy at age 65 is about 15 years but we can expect this figure to rise significantly during the next 30 years. In order words, the average life expectancy at the age 65 might be 30 to 31 years.



Too often the older American, instead of being welcomed and needed, feels neglected and resented. The life expectancy for women has increased much faster than for men and has therefore resulted in a growing perponderance of women in the population as we go up the age scale. More boy babies are born than are girl babies. But higher death rates for males does bring equality in numbers in the twenty-year-olds and then the females increasingly outnumber the males. At ages 65 to 69 there are in our population 120 women per 100 men; after 85 years of age there are 160 women for every 100 men. The average difference for all persons over 65 years of age is 135 women for every 100 men. This accounts for the fact that there are many widows in our society. We have a social custom where men in the older bracket marry much younger women. Thus today 40% of all older married men have wives under 65 years of age. Most older men are married and most older women are widows. Widows outnumber widowers by 4 to 1 and in the course of a year about 15,000 older women and 35,000 older men get married. By the year 2000 we are told that there may be as many as nine million aged widows.

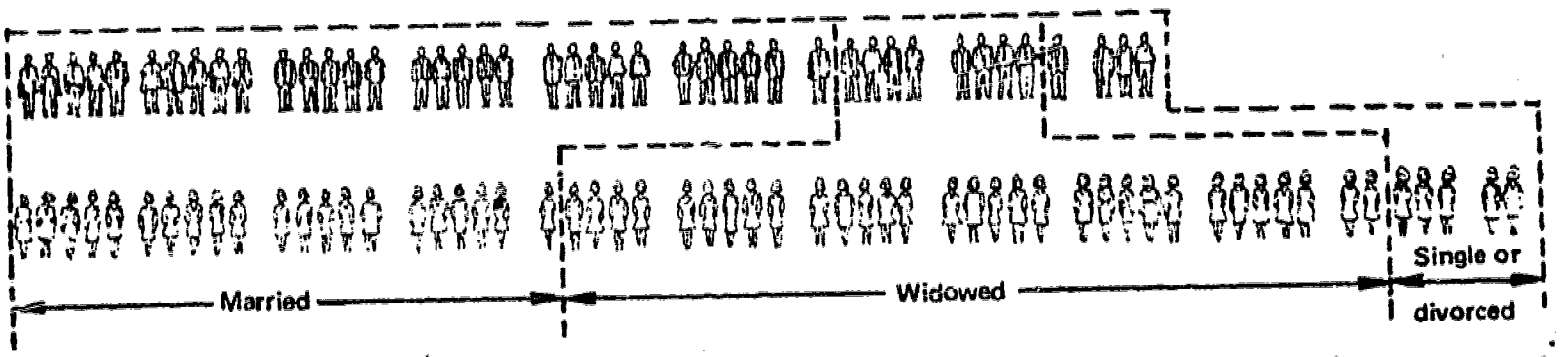
OF EVERY 100 OLDER PERSONS

(Each figures represents 200,000 older people)

SEX

There are 135 older women to every 100 older men. The ratio increases from 120 at age 65 through 69 to more than 160 at age 85 and older.

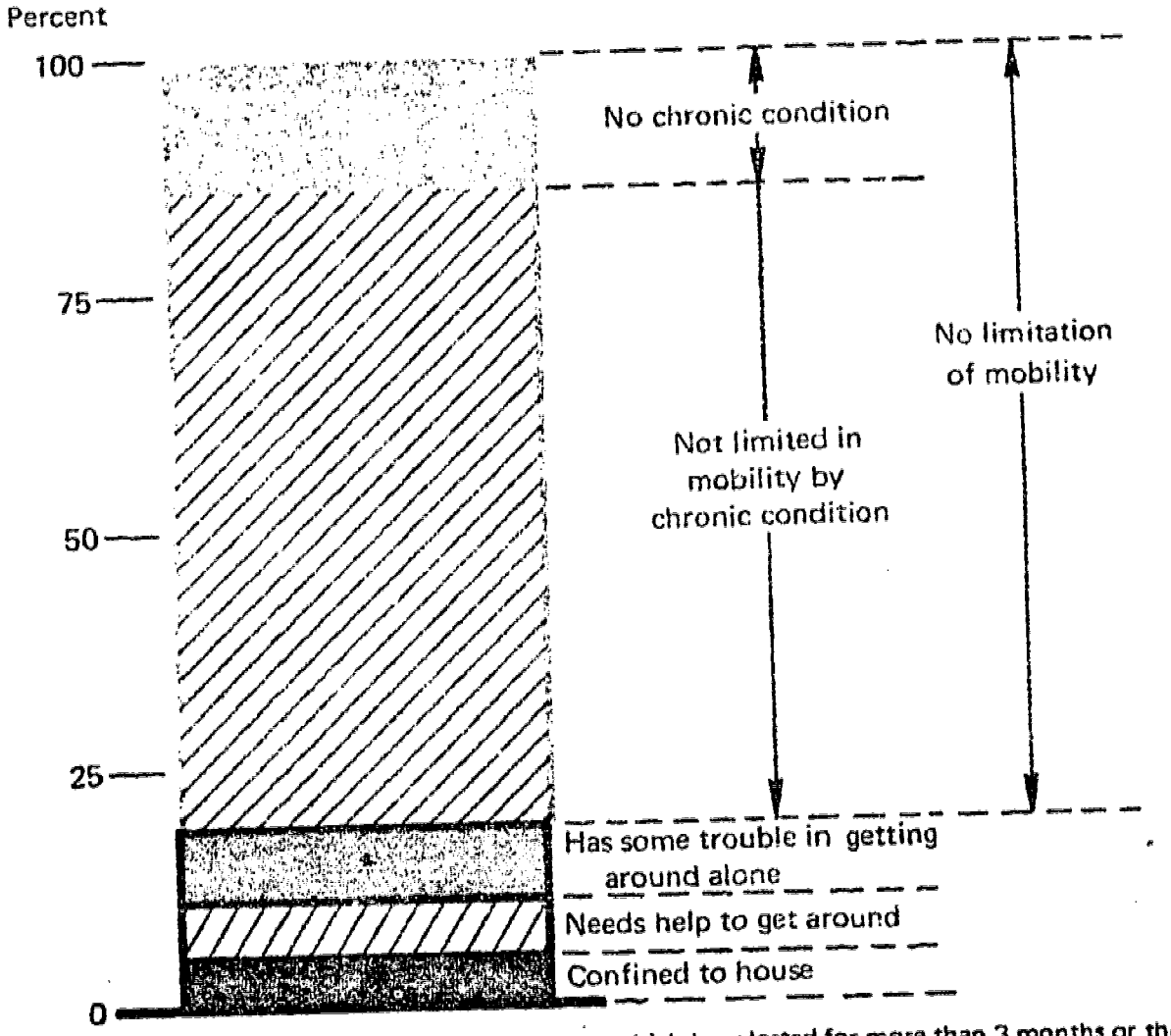
MARITAL STATUS



Most older men are married; most older women are widows. There are almost four times as many widows as widowers.

In our social planning we must consider the 4,100 persons a day or one and one half million persons a year who become newcomers to the rank of the aged. Urbanization brought the population into the city where it has aged but suburbanization has taken the younger population out to the edge of the city leaving the elderly behind. More than 80% of older men live in a family setting, 70% with a wife present, another 60% live alone or with non-relatives, and only less than 4% are in institutions. Among the older women, only 61% live in a family setting, only 34% with the husband present, and astonishing 35% live along or with non-relatives and only4% are in institutions. Over 95% of our older Americans do live in a normal community setting, not in an institution and they depend on community services. Of the older population living outside of institutions 14% have no chronic conditions, and 67% have one or more chronic conditions that do not interfere in any way with their mobility which means that a total of 81% have no limitations of mobility. Eight percent of this population does have some trouble getting around but are still able to manage on their own, and another 6% needs the help of another person to get around with only 5% being home bound. Too often we have had a picture of the older person as a dec epit faultering oldster and this has been over-exaggerated. The overwhelming majority of older people can manage in the community if society plans to develop programs of assistance and will help them with their self-expression. They would manage even better if society would encourage such activities and would provide the services needed. Persons over 65 have one chance in seven of requiring short-term hospital care and one of twenty-five of requiring long-term in any year. While only one of 50 of those between 65 and 72 require long-term care, one of 15 of those 73 and over requires this care. Older people do suffer more disabilities than the general population, they do visit their physician more often and spend more time in the hospital. In spite of these facts we discover that about five-sixths of the elderly get along on their own.

EFFECT OF CHRONIC CONDITIONS* ON MOBILITY OF NON-INSTITUTIONALIZED OLDER PEOPLE, JULY 1965 – JUNE 1967



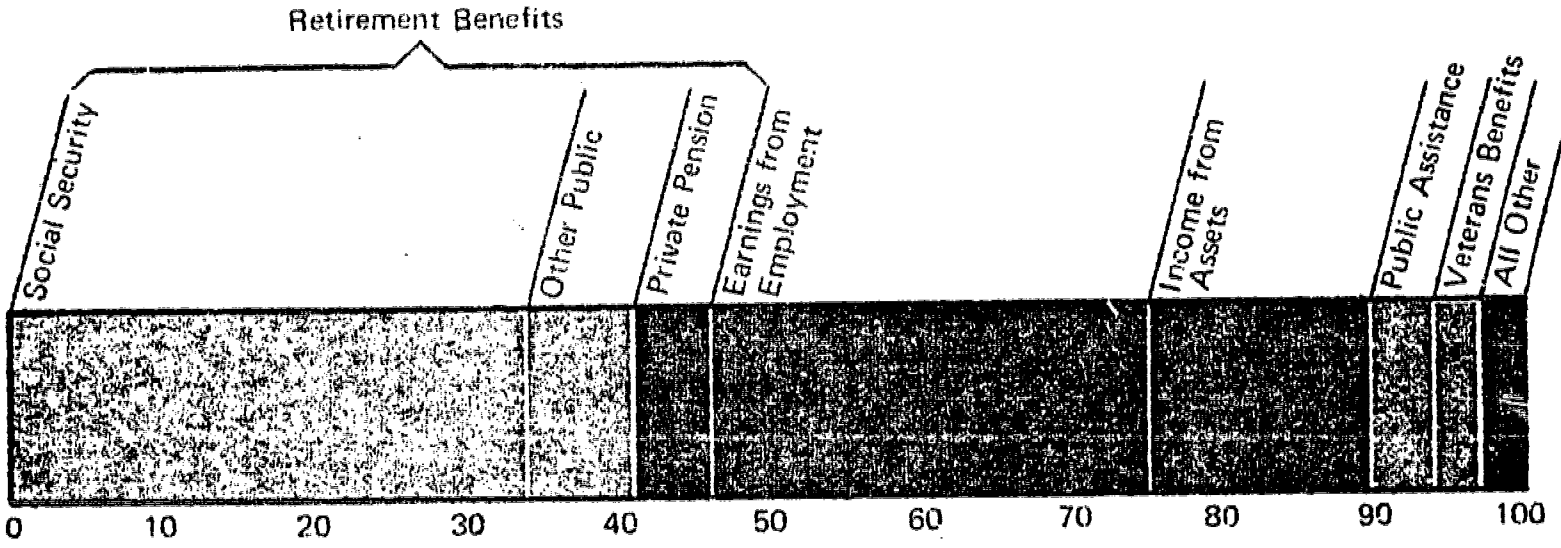
*Chronic conditions are conditions or impairments which have lasted for more than 3 months or those with an onset more recent which appear on lists of medically determined long-lasting conditions. They range from visual impairments corrected by eyeglasses to a completely disabling stroke.

The median income of older families and individuals is consistently less than half of that of their younger counterparts. In 1968 living alone the median income of older couples was about $78 a week and of older people or with non-relatives was $33 a week. This has, of course, improves greatly during the past three years with regular increases in social security payments and benefits from Medicare and Medicaid. As we look back to the statistical data of 1968 there were over four and one-half million or a quarter of all older Americans who lived in households whose total income was below poverty line for that type of location of household. Of all the aged poor about 65% were women and 85% were white. Aged makes up 10% of the total population but they do comprise 18% of the poor. If you are old you are twice as likely to be poor. Older consumers must spend more of their income on food, housing, housing operations, and medical care than do younger consumers. This would

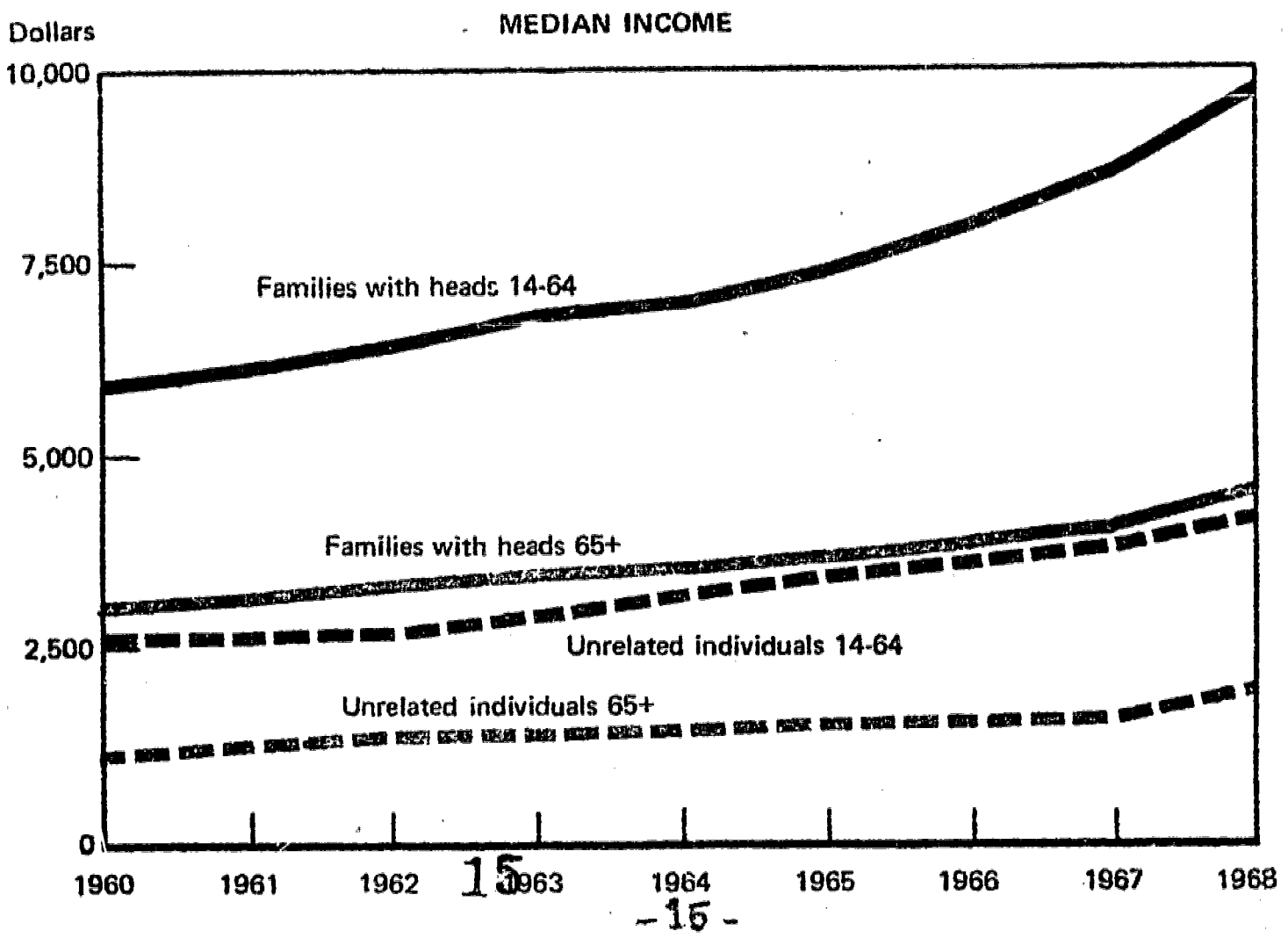
of course mean that they spend proportionally less on transportation, clothing, household furnishing and recreation. While the largest single source of the 45 billion dollars that comprises the income of the elderly is from earnings from employment, this represents a source of only about 20% of the aged individuals. Regular retirement programs contributed about 40% of the total income, with 30% coming from Social Security, 6% from Railroad Retirement and Civil Service, and 3% from private pension plans. In addition about 40% came from Veterans Benefits and 5% from public assistance.

INCOME SHARES, 1967

PERCENT OF AGGREGATE MONEY INCOME OF AGED UNITS FROM SPECIFIED SOURCE



MONEY INCOME OF OLDER PEOPLE



PERCENT DISTRIBUTION OF OLDER FAMILIES AND INDIVIDUALS BY MONEY INCOME IN 1968

Income	Families with 65+ heads					65+ Individuals living alone or with nonrelatives		
	Total	Male head, wife present		Other male head	Female head	Total	Male	Female
		All	Couple only					
	(7,076,000)	(5,602,000)	(4,457,000)	(334,000)	(1,140,000)	(5,292,000)	(1,322,000)	(3,971,000)
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Under $1,000	2.6	2.1	2.1	3.2	4.6	18.2	12.8	20.0
1,000-1,499	4.5	4.1	4.6	6.1	5.8	23.8	22.4	24.3
1,500-1,999	6.2	6.0	6.8	4.7	7.6	17.0	17.8	16.8
2,000-2,499	8.7	9.0	10.4	7.7	7.4	11.4	13.2	10.8
2,500-2,999	7.4	7.6	8.4	6.6	6.5	6.0	7.8	5.4
3,000-3,499	7.7	8.1	8.8	6.7	6.2	5.3	5.1	5.4
3,500-3,999	6.5	7.0	8.1	4.7	4.5	3.2	4.2	2.9
4,000-4,999	11.0	11.5	12.1	6.9	9.7	4.7	5.1	4.7
5,000-5,999	8.6	8.8	9.0	7.2	8.2	2.7	2.7	2.7
6,000-6,999	7.1	7.0	6.8	5.6	7.6	1.7	1.8	1.7
7,000-7,999	5.9	5.4	5.1	8.2	7.6	1.3	1.0	1.4
8,000-8,999	4.3	3.9	3.5	7.8	5.1	0.8	1.1	0.7
9,000-9,999	3.7	3.8	2.8	5.7	2.8	0.9	0.8	1.0
10,000-11,999	4.9	4.8	3.5	4.8	5.6	1.1	2.0	0.8
12,000-14,999	5.1	4.9	3.2	7.3	5.4	0.6	0.6	0.5
15,000-24,999	4.6	4.5	3.1	6.2	5.0	0.7	0.8	0.7
25,000-49,999	1.2	1.4	1.2	0.7	0.3	0.3	0.6	0.2
50,000+	0.1	0.2	0.2	0	0	0.1	0.2	*
Median	$4,592	$4,532	$4,038	$5,471	$4,758	$1,734	$1,916	$1,670

*Less than 0.05%.

Percent of Older People with 1968 Incomes of Less Than Given Amounts

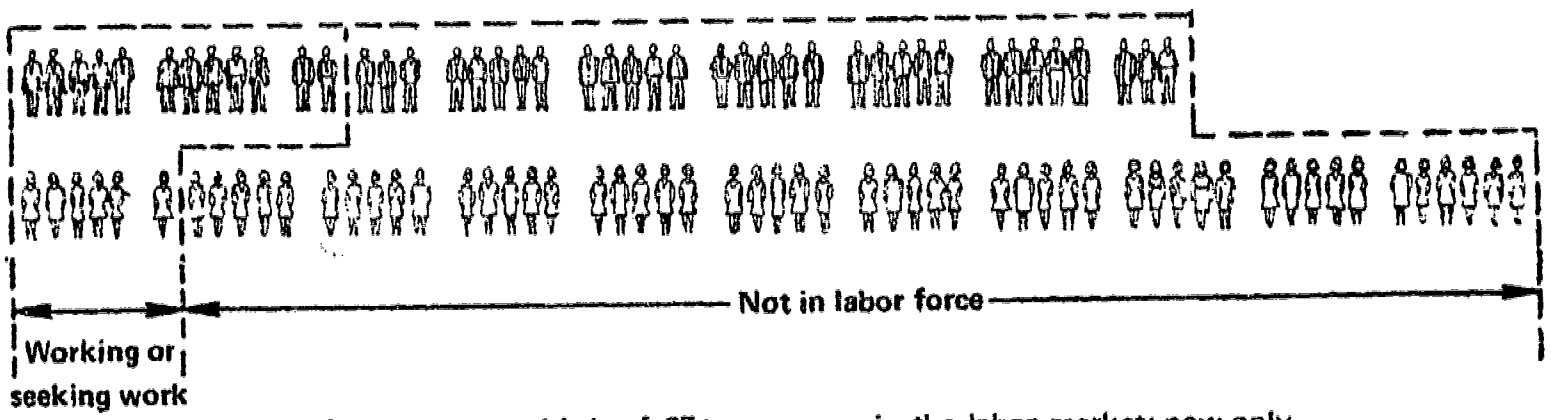
Income	Families (7.1 million)	Individuals (5.4 million)
$10,000	84	97
9,000	80	96
8,000	76	96
7,000	70	94
6,000	63	92
5,000	54	90
4,000	44	85
3,000	29	77
2,500	22	71
2,000	13	59
1,500	7	42
1,000	3	18

- Older families average just under half of the income of younger families; older persons living alone or with nonrelatives average only two-fifths of the income of their younger counterparts.
- In 1968, about a quarter of all older persons were living in households with incomes below the poverty line for that type and size of family.
- Almost 30% of the older families had incomes of less than $3,000 in 1968; more than 40% of the older people living alone or with nonrelatives had incomes of less than $1,500.

If we are to discover the source of our aging problems we must do more than just look at a compilation of statistical data. We must view the people and the society as a whole, taking into account the realities of an urbanized, industrialized, and technological age and all of the rapid changes which are implied. Older people today are no longer needed for supplying food, making clothing, providing medical care, baby sitting, and they no longer own the means of production such as the land, the tools, and the know-how to pass down to their children. Thus the older American has been pushed out of almost all of his formerly significant roles and concommitant statuses and today's older citizen lives in a state of isolation.

There are various opinions as to the relationship of the older American to the labor market today and the older American has found himself as a part of the legislative program related to non-discriminatory practices. One of the major social decisions of the next 20 years will be to determine what proportion of people over 65 should be in the labor force by the year 2000.

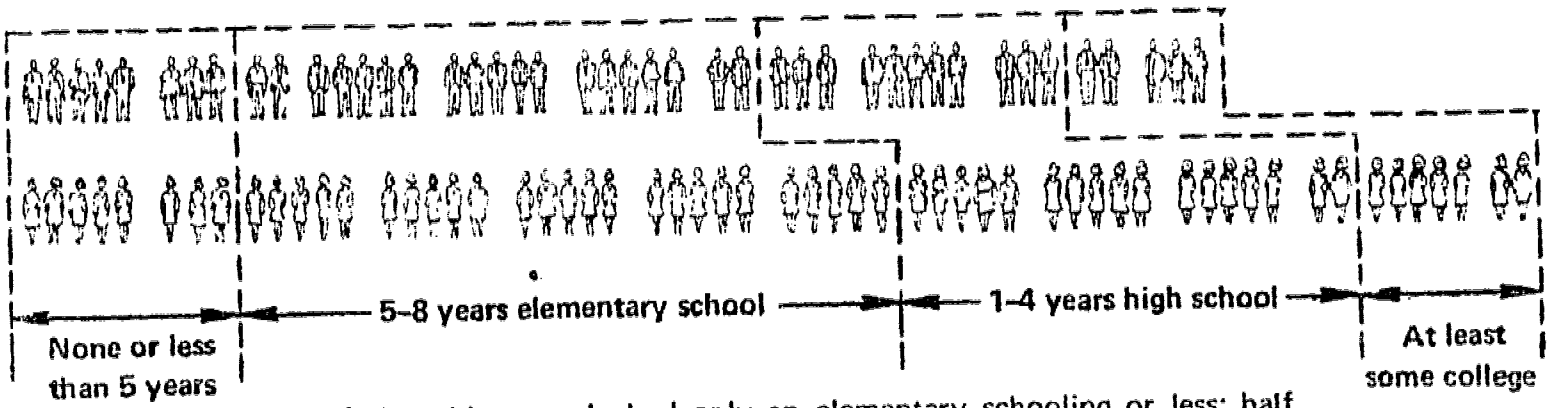
LABOR FORCE PARTICIPATION



In 1900, about two-thirds of 65+ men were in the labor market; now only about a quarter are. Rates for females increased from about 8% in 1900 to almost 10% now. The rate drops sharply after age 70. Between 65 and 69, 42.3% of the males and 17.3% of the females are in the labor market. After age 70, only 18.0% of the males and 6.1% of the females are working.

There are suggestions that there may be a direct relationship between successful adjustment in old age and educational attainment. About 20% of today's older population are foreign born and received some or all of their education in other countries. Fifty percent of today's over-65 group never went beyond elementary school. A million elderly persons in our society never went to school at all. It is estimated that about one-sixth of the elderly are functionally illiterate and only 5% are college graduates.

EDUCATIONAL ATTAINMENT



Half of the older people had only an elementary schooling or less; half of those under 65 years of age have at least high school. Of every 100 older people a total of 8 men and 8 women 65 and over had none or less than 5 years of school and are functionally illiterate.

Older people are concerned about political action. Our aged population represent about 15% of the eligible voters and in the future they will approximate 25% of the eligible voters. It was reported in the September 1971 issue of the AARP News Bulletin that "Older Americans vote in more impressive numbers than any other age group, according to a Bureau of Census analysis of the November 1970 election. Sixty-eight per cent of those 65 and over went to the polls. In the age group between 45 and 64, the turn-out was 74 per cent. Only 35.5 per cent voted in the 21 to 29 year age group. Thus society is making an impression on the pattern of living and the hopes and aspirations of our older population. In like manner older people are making an impact on society.

I tend to agree with the statement that the entire area of social policy in the human service and support field has been approached with less precision and reliance on research data than the physical planning policy field. It has been suggested that there has been more systematic analysis in highway planning, space utilization, flood control, outer space exploration, electric power distribution and port development than in the human service field. Nathan Shock has stated that the solution to the complex problems in gerontology will require the application of research techniques of practically every scientific discipline. Effective research needs to be or "must be" directed toward a specific question. Many broad and general questions of great social importance must be broken down into simpler and more specific questions before they can be adequately attacked by research methods.

One of the strange things to me is that older people sometimes seem to vote against themselves. I think that one of the reasons older people don't support more social legislation, much of which would be useful to them, is that they feel so financially insecure and they are afraid to vote for measures that are going to cost money. —Clark Tibbitts

Action for Older Americans

. . . and stumbling blocks to action:

Those of us in the field are probably the most guilty...of having created the image of aging that exists.

In our zealousness to try and promote support for a better life in retirement, to put some gold in the golden years, if you will, we've played up the hazards of being old to the point where most folks are beginning to believe that that, indeed, is what they can expect in their life. And rather than join the ranks of trying to change it, they have joined those who deny age.
—Bernard E. Nash

Stereotypes will break down by all kinds of formal and informal education. As old people change and are not any longer this desolate, passive, isolated group, attitudes are going to change. We need a great deal of input in terms of the mass media. We are creating the stereotypes that we object to and I think the mass media do it as much as any other major force in the society. For example, the generation gap is highly a creation on the part of the mass media, I believe. The mass media does very little to break down the stereotypes of the old, and they could do an enormous job. —Bernice Neugarten

The basic problem, I believe, has been society's failure to recognize fully that in this century we have had a revolution in aging.

Neither this, nor any other nation, has truly faced up to the implications of this revolution in aging. We have failed to see either its magnitude or its character—particularly with regard to heightened capacities for living by older persons.

We glibly use the figure, "20 million older Americans", but really fail to understand how big this is. It contrasts with less than 7 million 40 years ago. Only one-fourth of the world's nations have individual populations so large. Of the more than 100 non-Asiatic nations, only 16 have as many as 20 million in their whole population.

When one considers the talents, skills and experience among our senior citizens, the magnitude of this resource is enlarged further. We are short-changing both the United States and its older citizens when we refuse to give older Americans a chance to participate as fully as they can in our national life.
—Sen. Winston L. Prouty

Although we have today many reports, studies, investigations, articles and volumes on social gerontology, because of the increasing interests in this field and the new emphasis being placed by many colleges and universities in the area of gerontology, the goals for research have not been clearly identified. Dr. Clark Tibbitts has presented a broad review of research needs in social gerontology.(14) He has defined the goals of social gerontology as achieving and understanding of the manner in which time-related biological and psychological changes and environmental and cultural factors influence the development of personality and behavior of older adults, their roles, status, and collective behavior. He has suggested that the impact of our changing economy and the transition to an automated, cybernetic production system are major areas for study, even more important than the impact of changing birthrates, migrations, distributions and other population characteristics. He has raised three basic questions:

1. What is the position of old people in advanced society?
2. What are the roles for old people and can more acceptable roles be found?
3. Can old people respond to efforts to integrate them into a society characterized by rapid advances in knowledge and social technological change?

Related questions include the general one about the impace of large numbers of older people on structured institutions of society. There are many other questions which we might concern ourselves with today such as the meaning of work in a society where there are large numbers of non-producing persons. The meaning of retirement to elderly and to the young. How do social values change as we get older? To what extent are the conditions of older Americans today the result of the wishes and ideas of all Americans? Can national aspirations and values which impinge upon the life situation of the elderly be altered? To what extent do these values affect the self-image of the elderly and hence their behaviors and expectations?

Again referring to the Committee on Research and Development Goals in Social Gerontology of the Gerontological Society in their report made in the winter of 1969, "To be sure, a good deal of research must be directed toward the accumulation of basic information on the characteristics of the elderly, on the value system of our society, on the characteristics of younger populations who are to be the elderly of the future, as well as on trends and economic conditions, housing, population, transportation, labor force composition, and education." (15) Social gerontology does have an obligation to contribute material which will be useful for the formation of social policy. That Committee went on to suggest five steps which they felt were essential.

1. We must articulate with some degree of care objectives for life in old age. This framing of objectives should encompass both the long and the short range goals. These objectives would include such things as income which will be necessary to provide a certain amount of goods for decent living; income necessary to purchase services; housing of a specified quality; adequate health care and effective social centers.

2. We must distinguish among those human conditions which are fit objects for change through applied social policies and those which are not. There is ligitimate social policy which does leave some problems to the individual for them to solve, otherwise we regement and dictate to people just what their actions might be from day to day.

3. We must assess the value system in general and the value systems of the very old, the old, the newly retired, and those facing old age. What is it that each group is seeking in life as they approach or are a part of old age and what do they expect from society?

4. We must assess the state of knowledge relative to life in old age and identify the gaps in some organized way. What are the problems which need to be researched in this area and what systematic approach can we suggest for identifying the gap and the questions that are of importance in the formation of social policy?

5. We must establish a method and system for understanding research in line for social policy and the gaps that we have identified.

I have been hearing across our nation an appeal for a national idea about aging, a new approach to social policy. Dr. John Martin, Commissioner on Aging, has suggested that it is his desire that out of the White House Conference which will be held the latter part of this month that we will discover a national policy for aging. This certainly should give us a specific sense of direction so that our efforts can be expended in ways which will be fruitful as we seek to make our contribution to the field of social gerontology.

Many programs and services which have been developed and are functioning at the present time to help meet the needs of our aged and aging population appear to be successful and have survived the lack of supporting, definitive, scientific foundations. Inventories of rather easily observable characteristics and circumstances of older people coupled with common sense approaches by those who are working in this field have enabled us to make important advances. There is much to be learned about the processes of aging, about developmental behavior during the second half of life, and about the impact of older people on the organizations and institutions of society. Most of the programs we have developed for older people have primarily been guided by a set of values held by society relative to the aged and aging. Such illustrations could be found in various types of housing programs which we have developed to meet an evident need of our older population. I am sure that most of us would agree that

the direction in which we have been moving during the past ten years for the most part has not been rationally planned. There have been responses to problems with answers found as we have followed the line of least resistance.

Shelter

Some people get more of life's satisfactions, we are discovering, out of one kind of housing and some out of another, but, above all, housing ought to be planned so that it contributes to intimacy and friendship, and eliminates isolation. I think we say that either you give a person some intimacy or friends or he goes in a hospital.
—James A. Peterson

"I've always heard that solitary confinement is the worst form of punishment. Now I've seen what that means"
—Testimony from a Community Action Worker before the U.S. Senate Committee on Aging

If older people live in an area that has an approaching high crime rate, then they ought to face up to some real questions.

Is that a safe place to continue to live? Merely because they've lived there for many years and have family and other attachments, is it really desirable? I think those are hard questions for old people, but we know that their failure to face them has left many in jeopardy. Some we see come to relish fear. It's the excitement of their lives. It's the one thing they can talk about and think about. How many bolts you have on the door—not that you don't need bolts on your door, and unhappily the poorest are not going to have a door that will support a bolt. But the thing is, you cannot live a life of fear, you've got to seek happiness in life.
—Ramsey Clark

There is no serious effort being made to meet the housing needs of older people . . .

If we are really going to talk honestly—if we want to eradicate the poverty affecting the 7 million people who are over 65, it's going to be a multi-billion dollar proposition and I don't think America is ready for that. Secondly. I don't think it's able to move into housing. It hasn't been able to succeed in housing at all.
—Robert N. Butler

New winds are blowing and there is a new sense of direction as is evidenced by new developments and new problem-solving techniques within the major action areas of aging. Research is being developed to validate the ways in which we are dealing with problems related to aging. Research connotes a variety of methods which are utilized in order to acquire knowledge of the nature, etiology, and consequences of problems and evaluate the efficacy of the solutions devised. Research today ranges from surveys which collect readily obtainable information to designed experiments which seek definite answers to specific questions. If we were to ask where the action is related to aging we might immediately respond with "housing". The Welfare Administration of the Department of Health, Education and Welfare and the Public Housing Administration

of the Housing and Home Finance Agency entered into an agreement in 1963 whereby Housing For The Aged and Aging has become a primary concern and interest. In a Memorandum of Understanding signed in 1963 these two agencies agreed to initiate a program to promote and facilitate both the construction of public housing especially designed for older people and the provision of social, health, recreational, and other services to residents thereof. The aim of the program was to provide housing which would enable low income older people to meet the special social and health needs which increase with age, to afford privacy and independence, and to extend the period they are able to live comfortably and actively in the community instead of seeking accommodations in the homes of adult children or in institutions. Research problems created by this special concern are numerous, including such areas as architecture, econimics, sociology, social psychology, health and community planning. It has been suggested that some of the problems in this area of concern which need to be studied in detail are as follows:

1. At what ages or stages of life do aging people become candidates for special housing?
2. Is special housing for older people, such as apartments, hotels, urban clusters, conducive to an increase or decrease in social and community participation, in self-expression and life satisfaction, in health and independence?
3. From the point of view of utilization of costs, and of isolation of the individual from the community, what services are best provided in facilities located in housing projects? Which services can be brought to the residents by outside community agencies? Which can be best provided in outside agencies facilities?
4. What proportions of socially deprived, mildly confused, or physically marginal people can be absorbed in so-called normal housing for the elderly?
5. What is the financial capacity of older households to pay economic rentals or purchase prices for adequate housing?

There are many questions related to institutional type services for the aging. Medicare and Medicaid along with Intermediate Care program have raised many questions as to type of services needed and the whole concept of what we term "fragmentation".

I agree with Tibbitts and Shmelzer when they say that one of the most challenging areas for action in the field of aging becomes that of programming time.[16] Millions of older people are faced with finding ways in which to employ an aggregate of billions of hours of free time. Older persons find themselves released from the traditional responsibilities of early and middle adulthood which include wage-earning and rearing a family. Many older people do have the inner resources to develop new interests and create new places for themselves but many more seem to be unable to find new interests and therefore become "problems" in society. Society itself has helped to create feelings of uselessness among the aging population. Today senior centers across the nation, organizations made up of older persons, some for political action, others for recreation and education, are all helping to reactivate these persons. I have a personal concern for residents living in congregate homes who have tremendous resources within themselves to help meet some of the needs of the broader social problems of the community. We have therefore developed in our facility a program wherein retirees volunteer to assist in social action programs. We are involved in an educational and training program for physically and mentally handicapped and retarded persons. The residents of the facility volunteer time to assist with these programs. I have had a feeling that the explorations which we have made relative to free time for the older American has been concentrated mostly in the concept of senior centers. "individual frustrations and embitterment born of individual feelings of uselessness and marginality - be they those of juvenile, ethnic groups or older people - have reverberations on the total community"s welfare."[17] The search for uses of retirement is a new confrontation of American society; hence, there are many research areas which must be explored before we can proceed with confidence to extended program development. Again we face such questions as:

1. Will retirement be a time of shifting personal goals and activities or a prolonged period of withdrawal?

2. Is disengagement a natural inevitable process or a function of a culture which has few expectations for older people and limits their resources?

3. If retired people seek new activities will appeal be found in creative self expression, education, voluntary service, recreation, spectator activities? What are the variations by age, sex, physical status, education, social class, income? Are retirees interested? Will agencies use older people? What conditions must obtain, such as nature of service and payment of expenses? What other functions can senior activity centers serve in addition to leisure time programs? Could they also provide such services as counselling, information-referral, health, education and screening or retirement preparation?

Several years ago when I was attending the Gerontological Society meeting at the Waldorf Astoria Hotel in New York City I was to meet a friend at the Plaze Hotel just across the street. As I was sitting in the lobby waiting for my friend, a very attractive older person approached me with a smile. I responded in asking her how she was feeling today. She immediately responded, "I feel like hell." This of course was somewhat of a surprise to me in her response but I immediately asked her what her problem was. She informed me that she was "bored". She then proceeded to tell me of the many retirees who were living in flats and apartments in that section of Manhattan and how they had so much time on their hands that they became depressed and uneasy. Many of the people seated in the lobby at the Waldorf Astoria and the Plaza were retirees who lived in nearby apartments. I told her I was attending the meeting of the Gerontological Society and that we were dealing with such problems and issues. She informed me that she was a retired chemist - a professional person - and that she did not have a very large pension and was not able to do many of the things that she wished that she might be able to do. I expressed my concern and the next morning shared this with a workshop group when Dr. Wilma Donahue was asking how we could do the "leg work" involved in research programs. I suggested that we had retired professionals such as the lady that I had talked to the day before whom I am sure would be happy to make interviews, etc.

That evening as I was going into the Hotel, as I was staying at the Plaza, I met the lady purchasing the paper at the front door. She spoke very graciously and asked me if I had carried her concern to the meeting. I informed her that I had and she immediately asked what the response was.

I told her how I suggested that persons such as herself could help in the implementation of research programs. I had an immediate response from her in saying that this was not what she was trying to tell me. She really didn't want to become involved in a work experience but rather she was trying to tell me that she needed more money whereby she could take a taxi to the theater or share in cultural experiences which were meaningful to her. I have often times thought how this illustrates our response to older people and how many times we do not really understand what the problem is which they are facing.

I have always appreciated the formula that Dr. Edward Bortz who wrote the book Creative Aging and was president of the American Medical Association back in the mid 40s, gave regarding successful aging. I had the opportunity of visiting Lankanau Hospital in Philadelphia several years ago as a guest of Dr. Bortz for several days, in order that I might observe the team approach which they use directed to the problem of rehabilitation of the older person. Dr. Bortz suggested this formula:

$$\frac{E}{d} + M = f$$

Translated this means that Energy divided by dispersion plus Motivation equals Fulfillment. We will not take time to analyze this formula but simply state that motivation plays an important part in our concept of successful aging.

I would like for us to look at aging in terms of capacity to function physically, mentally, and socially. As we look at the aging process in these terms we do see great resources for adaptation, along with potential for independent and happy living. As is stated in the U.S. Department of Health, Education and Welfare document, Working With Older People-A Guide To Practice, Vol. 1, "The aged person is a continuing challenge. The physician and other practitioners - nurses, dentists, social workers, to name a few - must preserve what can be preserved, improve performance with symptomatic treatment and special aids, and never be discouraged because an outright cure is lacking."(18)

Thus it is easy to understand how motivation is different in the aging from what it is with either the middle age or the young. The normal ambition and competetiveness of the younger years is often times succeeded by interspection and a desire for security even a feeling of complete dependency. Older persons may not have the desire to recover from illness because recovery would signify the renewal of old problems and old struggles. Thus the goal of those who work with and for older persons is to maintain structure without major loss, to make an effort to promote ability to handle stress, and to help the older patient attain and maintain the maximum physical and mental efficiencies of which they are capable. I would like to lift out for you several suggestions made in the document Working With Older People as related to the suggestion that we today who work with aged are increasingly aware of the relationship between the physical and the psychological factors in the lives of aged patients;

....-of the impact of retirement, loss of income and prestige and dependency;

....-that the elderly man keenly feels the waning of strength, the lack of usefulness in society's eyes;

....-that the elderly woman, perhaps widowed, may be overwhelmed by her loss, conscious of fading place in her children's lives, and worried about diminished income and health;

....-of the impact of these anxieties on physical conditions and of physical conditions on these anxieties;

....-that health has a greater influence on a person's concept of himself than does age;

....-that personality changes and the psychological effects attributed to aging are in large measures reactions to health status rather than to chronologically determined processes alone;

....-that factors of class, culture, economics inhibit the patient's obtaining or using proper medical care, and that these factors of the patient's attitude toward health and aging must be understood both by the practitioner and patient;

....-that attitudes and definitions of health vary by social class, finances, country, culture, age,sex, occupation, and that many of these outlooks lead elderly people to accept certain symptoms and disabilities as natural or inevitable;

....-that the elderly patient needs assistance in sustaining a sense of worth and dignity;

....-that we must treat the person, not the symptom.

I would like for us to think about health as related to the aged person. We are told that the World Health Organization views health as a "state of complete physical, mental and social well being and not merely the absence of disease or infirmity." Good health has been defined by Dr. Samuel Gertman as "a state in which there is maintenance of structure without major loss, a continued ability to handle stress, in the attainment and maintenance of the maximum degree of physical and mental vigor of which one is capable." The Committee on Health Maintenance of the Curriculum Project of the Gerontological Society, defines healthy aging as the ability to function without more than ordinary help from others. In other words, they see it as the ability to function with, and despite, disabilities - as the capacity for adapting well.

America's Medical Bill . . .

America's medical bill in 1970 amounted to $70 billion, 11 percent more than in 1969 and approaching three times the amount 0 years ago-($26 billion in 1960).

Of the growth in medical expenditures in the last decade, fully 60 percent can be attributed to inflation—not additional or better health services.

Since 1960, medical costs have gone up twice as fast as the cost of living; hospital costs five times as fast.

In the two year period ending June 30, 1969, health expenditures for the aged rose to 42.2 percent, twice as fast as expenditures for younger people.

—Developments in Aging 1970
A report of the Special
Committee on Aging,
United States Senate

Many of us in medicine, including the medical faculties, have taken what is acute, interesting, exciting and high cost and left what was chronic and not so interesting—the dismal social problems, the grinding issues—to everybody else. In the field of medicine, the health field has got to revise its practices and its tradtional ways of delivering health services to accentuate lower cost service, the social issues and social roots of disease. We, in medicine, should be in the forefront of fighting for better income for elderly people and for revision of Social Security. I think that we are in a watershed era in this country right now. We are in a slack tide, but this next decade is going to see much more emphasis on these things.

—John H. Knowles, M.D.

It is clear that we have to move on past Medicare.

—Robert J. Havighurst

Practitioners - those from various disciplines who work with the aged and aging may have misleading ideas about our aged population. Many of them deal with older adults at a time of crisis when the dependency needs of the older person are great. Practitioners often times fail to see the possibilities for growth and development that exist in older adults. I am sure that all of us could lift out illustrations where professionals have failed to see the potential within the older person to be rehabilitated or to live a normal life. I will share with you some suggested misconceptions which practitioners sometimes hold and see how you might respond to them. Some of these misconceptions are as follows:

1. Most old people live in institutions....
2. All old people are alike....
3. Most aging persons are sick, friendless and without resources....
4. Most older adults are handicapped by chronic disease....
5. Most older people lose contact with their families....
6. Most older people are not able to make their own decisions....
7. Old age is second childhood....

There are many others that we could probably add to this list but these will suffice to accentuate a particular concern of mine in changing stereotypes and misconceptions about aging and aged.

Many Gerontologists are encouraged with the implementation of the team concept in concern and care for our aged and aging. The "team" includes not only those who touch directly the lives of the older person but those who indirectly have some responsibility to the older person. We think of those who have primary responsibilities such as the physician, the social worker, housing personnel, administrators, recreation workers, retirement counsellors, ministers, and specialists in health care fields. There are others who have an indirect responsibility to the aging and aged such as the druggist, the banker who handles their money or the trust officer, the man in the shoe store who has the responsibility to be sensitive to their particular needs for comfort in that area. Then there are the many other persons who touch the lives of the older people such as the bus driver who can encourage by a friendly smile or a cheery

word, the clerk in the store and those people who have intermittent experiences with them. This, of course, would include the mailman who would have a rather important relationship with the older person on a day to day basis.

Dr. E. Frank Ellis who is the Director of the Department of Public Health and Welfare for the city of Cleveland, Ohio, speaking at the meeting of the National Council on Aging in St. Louis, Mo. in September of this year, made a suggestion related to the special needs of older people who remain in the community.(19) He spoke of a group which he called "Gatekeepers" and defined them as a person other than a health practitioner who is apt to hear informally about another person's concern over health and who at the same time is in a position to pass to potential patients information about sources of health care. In the instance of home bound elderly, ministers, postmen and pharmacists are natural gatekeepers. He told how in Cleveland the postal union express real interest in assuming the function as a public service. In this approach the Gatekeeper is seen as a pivot between patients and the health care systems. His potential role is viewed as three-fold:

1. to serve as a channel of communication
2. to direct or refer potential patients to entry points in the health care system
3. to direct health personnel to potential patients who have indicated an interest in receiving services but who, for any number of reasons, are not now participating in the health care process.

In this role the Gatekeeper is not seen as an advisor in regard to health problems or method of treatment. This role, stated Dr. Ellis, even though it presently is being assumed by some Gatekeepers, should be actively discouraged. Instead, one function of the Gatekeeper could be to serve as an interpretor. The Gatekeeper thus acts like a relay station in interpreting the population group being served to the health purveyors and the health programs and systems to the home-bound elderly. Like an antenna, the Gatekeeper can alert health personnel to a growing problem of retirees in a neighborhood. So, too, the Gatekeeper can help health personnel to better understand cultural patterns which effect health care habits of the aging, such as indifference to preventive services or ignorance of

symptoms. The Gatekeeper can reverse the process and tell elderly persons in the neighborhood about efforts on the part of providers of health services to adapt to their needs and to stimulate an interest in health care.

He went on to say that another function might well be to identify persons who might be in need of assistance. For example, a postman going about his daily delivery becomes well acquainted with a neighborhood. He sees and converses with many people, and inevitably becomes familiar with peoples habits. He may be the first to recognize something is wrong when an elderly person does not appear for a daily exchange of pleasantry or mail accumulates unexplainably. A call to a public health nurse may well be advisable. A Gatekeeper might function as an appointment agent. A man might well complain to a pharmicist about some ailment while buying some incidental item. The Pharmicist at that point easily could help the purchaser make contact with a source of health care. The Gatekeeper must be interested in help, alert to the possible contribution they can make, and aware of the potential dangers of exceeding their defined roles. The Gatekeepers must be well acquainted with resources, their structure and services available. There would need to be consistent followup on the suggestions and leads of the Gatekeepers and there would need to be feed-back to the Gatekeepers on the effectiveness of their role, not in terms of a patient's diagnosis but in terms of general changes in use of services and improvements in the communities health care status.

The team concept in health care is finding more and more tangible expression because it reflects the reality of the situation and the needs of all human beings, but particularly the aged.

The rehabilitation team is a dramatic example of how the knowledge and skills of many different disciplines are harnassed toward a single goal of restoring a disabled individual to maximum function. Maximum function is measured as much in terms of social and psychological functions as in terms of physical function. The health care team integrates the skill of the physician, the visiting nurse, the homemaker, the dentist, the physical therapist, the social worker, and/or others. Senior centers and recreation centers are becoming centers of total concern for the total needs

of the aged person. These are suggested principles for practitioners from various disciplines working with aged and aging.

1. The practitioner should understand the inter-relatedness of the aged person and his environment.
2. The practitioner should look at the whole person - medically, psychologically, socially - and not just at symptoms.
3. He should establish goals: to restore the sick to health, to help the individual function at his best. These goals are not only needed for the aged individual; they are necessary for the practitioner who will otherwise feel frustrated.
4. He should establish different goals for different individuals in different situations.
5. His basic goal should be treatment of specific diseases as well as to help maintenance and promotion.
6. He should utilize the full range of the community's health and social services in an integrated approach. He will recognize that every health practitioner will have a contribution to make.
7. To obtain optimal, physical, mental and social well being, and the individual should strive to improve hos own health, practitioners should provide skill in guidance, and society should offer the settings for organized health activity.

Communities need to offer a variety of alternatives to match the variety of individual needs among our aged and aging population. Without variety a real choice is absent for the older person. As an example, an aged person would have no real choice whether he is to remain at home rather than to live in an institution if services are lacking for home care, including homemakers, visiting nurses, home medical care and portable meals. A number of community development programs have been established through the assistance of funds through the Older Americans Act. These programs have simply touched the surface in relationship to the responsibility of meeting the real needs of our older population. Priorities have had to be developed in communities to discover which services were most needed and how they could be funded and implemented. Community planning must consider goals and circumstances in the design of specific services.

We have just begun a program in Morgan County, Indiana through assistance of funds under Title III wherein we are going to make an effort to discover how the services available in a congregate home and geriatric

service unit can help meet the real needs of the older person in the total population of a county. We too, will have to establish priorities as we discover the real needs. It may be that we will discover that the Meals on Wheels program should have first priority or it may be that home health aid services or home services wherein we can assist with housekeeping and the purchase of supplies such as groceries of older persons limited because of transportation or physical handicaps will need to be met. Services should be designed which will permit the older person to participate in community life, utilize his capabilities in ways recognized as socially worthwhile and which will assist the older person to adjust to social roles.

We as practitioners related to various disciplines need to help bridge the gap between the community and the individuals. Services should be comprehensive and should include prevention, early diagnosis and treatment and rehabilitation. I would like to share with you 15 suggestions for specific vehicles for health maintenance for our older population:

1. Diagnostic centers
2. Geriatric hospital facilities including daytime nonresident care
3. Hospitals with ambulatory and home-care programs.
4. Nursing and convalescent homes.
5. Visiting nurse programs
6. Programs lending hospital equipment for home use
7. Vocational rehabilitation and counseling services
8. Physical rehabilitation units
9. Homemaker, friendly visitor, meals-on-wheels and other home services
10. Housing projects and placement facilities including listing of good quality foster homes, nursing homes, and a variety of public and private dwellings
11. Programs for financial assistance, income-maintenance and employment opportunities
12. Information and referral services that tell the individual where to obtain legal, family, recreation, and welfare help.
13. Counseling services in mental health and family needs
14. Leisure time facilities and programs
15. Public health clinics and other facilities offering health information, screening and immunization programs, and safety and accident prevention programs.

The growing aging population does confront society with many difficult problems. Solutions can be found for these problems as it is certainly not beyond the capabilities of our human and scientific technology or beyond our financial capacity. I agree with those who have said that a society that

attacks with self assurance the problems related to living in such hostile environments as the bottom of the sea and outer space has the know-how and the means to solve the problems of the known environment of its own community (20). A society which is learning with whatever difficulty, the basic human value of loving one's neighbor regardless of race, color or creed can and should learn to love its neighbor regardless of age. A society which has developed its communications and systems of education to give its citizens as a nation a self image of leadership in the world and has given its youth a self image that the future is theirs can and should give to its older citizens a self image of worth and belonging. A society which has learned to "individualize" the countless particles of the atom, to "individualize" the countless organisms of disease, which has built machines to "individualize" all of man's knowledge, surely such a society can learn to individualize the needs of its aging citizen and to accept these aging citizens themselves as individuals.

Dr. Morris E. Linden said some 12 years ago that the need to foster the functional integrity of older people, to promote a personal dignity, independence, and sociability, and to practice physical and mental health maintenance is leading to program reforms throughout the country. (21) He went on to say that the changes then taking place were the result of recent researches, education of the public, revision of official standards, and improved communication between gerontological experts and institutional administrators. He further suggested that perhaps the key concept that lies at the base of program reforms was the increasingly realization that the psychosis of this senium are not the inevitable and inexorable resultants of biologic events in the later years. He stated that there are presumptive findings being validated by ongoing researches that demonstrate the value of furnishing specific supplements for the defined needs of the elderly in order to prevent many of the psychologic and physiologic ailments hitherto considered unavoidable.

Our friend and colleague, Dr. Donald Kent, has said, "The fact remains that for many Americans, old age is a time of harvest, of contentment, of satisfaction. That it is not so for all, is only partially a fault of the social structure - obviously other factors are operative." (22) Simmons

has written, "the secret of success for anyone facing a long life.... is to find for hi self a suitable place in his society in which to age with grace and usefulness, and to participate tactfully and fully up to the very end if at all possible."(23)

Three thousand delegates will converge on Washington, D.C. to participate in the White House Conference on Aging in three weeks. They have been commissioned to produce a design for achieving a satisfying future for all aged and aging Americans. In the Administration on Aging Publication, Invitation To Design A World..Second Reade, we are challenged to help bring about "an ideal world."

The ideal world would be where:

***every older person would have enough income to pay for nutritious food, a comfortable home, the clothes he needed, transportation when he needed it, medical care and medicines, and participation in the total life of his community. This document suggests that society may be able to begin building an ideal world where everyone has an adequate income by identifying what "adequate" is. Should society provide the income needed by older people and then protect this income against inflation, or should low income be compensated for by subsidizing service? (Medicare, Medicaid, Rent supplement, etc.)

***older people who wanted and were able to work would be able to find a job. An alternative to the emerging pattern of early retirement has been suggested. Leisure or free time which results from increased national production could be spread throughout the work life. This would involve shorter work weeks and time out for travel and/or education.

***everyone would be able to eat as much of the proper foods as he needed. There are many reasons why the diets of older people may be lacking in essential nutrients - - poverty, transportation, dental needs, isolation and special need.

***older people would be able to get the medical care they needed, when they needed it, at a price they could afford. Such care would include preventive measures, treatment when needed, various types of services with rehabilitation as constant goal.

***older people would have a number of choices of where to live and how much to spend. Under the low-rent public housing programs, 287,000 units for the elderly have been completed; for middle income older people 33,000 units accommodating 45,000 persons have been completed under the Federal direct-loan program and 10,000 more units will soon be completed. Another 2,300 have been built with rural housing loans. For the more affluent, 40,000 units have been built under the mortgage insurance program. This is but a token response to a need where eight million older persons are poor or near poor.

***transportation to stores, clinics, clubs and other community activities would be available to all older persons. Only about 40 per cent of those over 65 years of age have drivers licenses. There are answers to these problems and we need to help in their discovery.

***older people would have a definite place and status - - a feeling of still being useful, needed and counted. In 1964 there were 334 multi-purpose senior centers open several days a week. In 1969 a survey revealed 1,200 such centers in operation.

***each individual would be able to find education tailored to his needs any time during his lifetime.

***all older people would have meaningful roles and they would be assured of fulfillment and a satisfying old age. Maintaining spiritual well-being is particularly hard for old people.

***to make a better world for older people, systematic planning is necessary. Some 20 Federal Agencies have statutory authority for programs and services for older people. We need a concerted effort to assure that the needs of our older citizens are met.

***we must have the resources, the facilities, programs and services to meet the needs of older persons. This will require the coordination of th efforts of voluntary and governmental agencies.

***we must have skilled and motivated people to provide services and administer programs. We must have many more persons trained to deliver specialized services and training programs to prepare such personnel.

***research and demonstration are needed to determine the best methods for improving the world for older people and to help us forcast how many people may exist in that future world. Based on annual Federal expenditures of some two billion dollars for health and welfare programs for older people, the current research investment in aging is about .2 per cent.

It has been suggested that every speaker advocating truth should adjure his hearers as did Socrates his in Athens. "If you will be persuaded by me, pay little attention to me, but much more to the truth, and if I appear to you to say anything true, assent to it, but if not, oppose me with all your might, taking good care that in my zeal I do not deceive both myself and you, and like a bee depart, leaving my sting behind." A decade later, his pupil, Plato, softened this a bit and these words are applicable today; "Truth is the beginning of every good thing, both in heaven and on earth; and he who would be blessed and happy should be from the first a partaker of truth, for then he can be trusted."

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