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ABSTRACT

This document contains eight papers presented at the 1981 White House Conference on Aging. Each paper begins with a statement of a Congressional finding relevant to the topic under consideration, followed by a presentation and discussion of important issues related to each topic. The first paper, "Research on the Aging Process," explores the scope of research on aging and considers biomedical, behavioral, and social science research. The paper on health care investigates shortcomings in Medicare coverage, mental health needs, and the delivery of health care services to older people. An examination of housing and housing services for older people discusses owner-occupied housing, rental housing, and the need for coordination of community resources. A social services report focuses on the Older Americans Act and the delivery of services to older people. A paper on long-term care considers the continuum of care needed by chronically ill older people and discusses both institutionalization and home-care alternatives. Employment opportunities for older people and the ramifications of a national retirement policy are also reviewed. The final paper focuses on the elimination of negative stereotypes toward aging and older people. (NRB)

WHITE HOUSE CONFERENCE ON AGING, 1981

Papers Prepared by the Gerontological Society of America

Papers presented at the White House Conference on Aging, Washington, DC, November 30 - December 3, 1981.

Prepared by
The Gerontological Society of America
as a contribution to the
1981 White House Conference on Aging

A.I.D. #1: RESEARCH ON THE AGING PROCESS

CONGRESSIONAL FINDING: "There is a great need for a national policy with respect to increasing, coordinating, and expediting biomedical and other appropriate research directed at determining the causes of the aging process."

Aging will be accepted as a normal part of the life process only when its biological causes are clearly stated and widely understood. The information needed for such statements and such understanding is as yet unavailable to us, despite the effort to pinpoint the cause or causes of the physical changes associated with the advancing years.

ISSUE: What should be the scope of research on aging?

Discussion. The establishment of the National Institute on Aging (NIA) in 1975 provided a national base where prior knowledge and research resources could be linked with new efforts not only at the NIA but in other Federal agencies as well. Dr. Robert N. Butler, Director of NIA, made it clear early in his tenure that he viewed the Congressional mandate for the Institute to extend beyond the study of the decline, losses and decrements commonly associated with aging.

> Rather, it is the study of the normal processes of development--continuing growth and creativity, judgement, and wisdom--which are fundamental to life and about which we know precious little. Indeed, a major objective of the Institute's research is to examine the variety of factors--biological, social, and psychological--which constitute the aging process and its debilitating accompaniments, and then to use this knowledge to prevent, modify, or reverse the latter so that the quality of life is better (1976)."

To help assure that the National Institute on Aging fulfills its Congressional mandate, the law establishing the Institute also called for a research plan "designed to coordinate and promote research into the

biological medical, psychological, social, education, and economic aspects of aging" ("Research on Aging Act of 1974", Public Law 93-296, 1974). Three advisory group study panels dealing with biomedical research, psychosocial research and the human services and delivery systems were established to develop such a research plan. This Agenda Issue Document is based in part on their summary report (Our Future Selves, U.S. Dept. of Health, Education, and Welfare, 1978).

BIOMEDICAL RESEARCH

Two types of research are included here: basic biological research and clinical medical research. Basic biological research included research which is designed to elucidate the following:

1. The long-term biological phenomena or biological clocks--pacemakers.
2. The location of the "clock" or network which generates the clock.
3. The nature of the clock: chemical (DNA), cellular, systematic.
4. The relation of aging of the clock to the aging of individual cells, tissues, and organs.
5. The relation of the clock to various defined disease processes.

Medical research on aging includes those groups of studies which are designed to elucidate the medical consequences of the aging process:

1. Atrophy of muscle, immune system, nervous system.
2. Origin or genetics of the differing sensitivities of individuals to these forms of deterioration as well as the differing longitudinal sensitivities of individuals.
3. Early identification of these tendencies, as well as identification of proximate causes, and intervention.
4. The alleviation of the advanced symptomatic stages of disease.

According to the NIA study panel on biomedical research, research on aging must seek the relationship between basic biological processes and disabilities. Research on the biology of aging involves virtually all of the major ailments of modern man. However, the approach of investigators in aging research is unique: the emphasis is not so much on the specific

disease process, but on the genetically controlled, time-dependent mechanisms that result in progressive changes in structure and function of the body, changes that are likely to set the stage for disease. Investigations must be carried out on many levels--molecular, cellular, tissue, organ, organ system, individual, and population. Eventually, a detailed understanding should emerge of how some interactions between an individual's nature (his genetic endowment) and nurture (the environment to which he is exposed) result in the processes of bodily decline which accompany increased age (U.S. Dept. of HEW, 1978, p. 1).

ISSUE: Whose responsibility is the conduct and support of biomedical research?

Discussion. Basic biological research relevant to aging is carried on by research foundations, universities, and medical schools. Such research has been supported by its host agency, the federal government and private foundations. Dr. Butler makes a case for a broad base of support for such research.

> "Some national policy makers, perhaps naturally in search of quick payoffs and instant cures, have mistrusted the scientists' long years of step-by-step, basic research in biochemistry or cell biology. They have considered this "test tube" research impractical, without directed goals, and not tied closely enough to human health needs. But such research can be the most people-oriented, the most practical research of all! Without such research, which, in the past years, has attempted to understand the components of the cell--their organization and basic chemical reactions--we cannot investigate regulatory mechanisms. Without such research we cannot develop the base on which to build, and produce the most stunning and practical results--like the polio vaccine, or penicillin, or the discoveries of last year's Nobel Prize Winners in Medicine, Dr. Baruch Blumberg and Dr. Carlton Gajdusek" (1977).

Clinical medical research relevant to aging, like basic biological research, is carried on in a wide variety of settings--hospitals, universities, foundations and medical centers. Such research is supported by

both public and private funds. In a time of decreasing availability of research funds the financial burden of basic research should be spread over as wide a base as possible.

From its very inception the National Institute on Aging and its advisors have sought an approach that will help assure that findings will be disseminated in productive ways. The Institute has used consensus conferences, under which already available knowledge is gathered and disseminated, preceded or followed by an interpretative conference. Conferences have been held on such topics as mental impairment, pain, and estrogen replacement. The Institute has maintained an extensive program making cellular and animal resources available to qualified investigators. Much of biological and medical aging research depends on the development and availability of such resources.

BEHAVIORAL AND SOCIAL SCIENCE RESEARCH

Old age does not occur in a biological vacuum. The sum of a person's life experiences does much to determine how that person ages and how he or she feels about being old. Accordingly, research is needed in many areas concerned with the social, cultural, economic and psychological factors that affect the process of aging and the place of older people in society.

As the NIA study panel on behavioral and social sciences research reported, chronological age in the second half of life is related to increasing risk of decrement, morbidity, and mortality. The majority of older persons, however, do not decline markedly in a variety of intellectual and social competencies until very advanced old age. Where declines do appear, they occur primarily in those tasks in which speed of response, integrative processes such as reasoning and the need for new learning, and

the ability to concentrate are critical. Appropriate teaching methods may facilitate compensation for some of these declines (U.S. Dept. of HEW, 1978, p. 10).

The NIA panel also pointed out that studies of development in late life have shown the importance of environmental variables and personality characteristics in understanding behavior. The vast individual differences among older adults may be attributed to both environmental and personality factors as these affect physical and mental health in old age. Environmental variables that have influenced the individual early in life, for example, his or her level of formal education, are related to social and psychological competence in old age. Moreover, the differences between younger and older persons that are attributable to the effects of aging (maturation) or which are attributable to differences between cohorts (groups of persons who were born at different points in history and who therefore have had different life experiences) may vary across successive generations (U.S. Dept. of HEW, 1978, p. 11).

ISSUE: How should behavioral and social research relevant in aging be supported and in what settings?

Discussion. A broad range of research is subsumed under the above heading ranging from physiological psychology to the demographer's study of populations. The subject matter of behavioral and social research lends itself to both applied and basic research. As an example, knowledge gained about normal age changes in vision has shown that commonly used vision tests for drivers' license testing may not be suitable for the assessment of older adults.

The question of the proper settings for behavioral and social research

has no simple answer. Because of the differences in development in the psychological and social sciences, the possibilities of supporting major centers of research may need to be evaluated on a case by case basis. Merely having a collection of behavioral and social investigators from different fields with a common interest in aging does not insure better research beyond that resulting from the higher morale of the research staff and students.

HUMAN SERVICES AND DELIVERY SYSTEMS

The NIA study panel on research on human services and delivery systems reported that research on the type, extent and manner of delivery of services to the aged overlaps with research in the biological, medical, psychological and social fields. This third sector of research on aging is a bridge between the research findings of these other disciplines and the provision of services. This research is primarily concerned with measuring the magnitude of service needs in populations, the corresponding needs for and availability of the manpower and facility resources to meet those needs, the manner and extent of use of those resources, the ways in which service systems are organized and function, the kinds and content of services received, their quality and cost, and how they affect people's well-being (U.S. Dept. of HEW, 1978, p. 16).

ISSUE: How is the basic vs. applied research dichotomy resolved in studies of the human services and delivery systems?

Discussion. The interplay between applied and basic research is closer in this area than in biology, medicine or the psychological and social sciences. Careful attention needs to be given to how human service delivery systems operate and how they can best serve their designated clientele.

ISSUE: How much effort should be given to evaluation of service delivery programs?

Discussion. Some have argued that the costs of properly evaluating a new program for providing medical and social services are so high that they operate to deprive some needy persons of these services. At the same time federally mandated and support programs of social and medical services on behalf of those requiring long term care, for example, now typically require evaluation. Resources, however, are frequently not available to carry out this mandated task. Further, many caregivers are reluctant to spend considerable effort evaluating what appears to them to be already a good program. These factors, plus the acknowledged practical difficulties in carrying out evaluation research, must be weighed against the potentially negative consequences of setting in place untried and often expensive programs without providing for evaluation of their efficiency or effectiveness.

PERSONNEL AND RESOURCES IN AGING RESEARCH

ISSUE: How should research be related to training of personnel?

Discussion. It is useless to state that services to older people are needed unless information is developed about what these services are, the effects of these services, ways to deliver service, and the cost/benefits of programs. At the same time a cadre of personnel, both research and service providers, must be trained and available to staff and evaluate such services.

The contributions of research in aging have been substantial to this time. Myths, once believed, have been discredited: the myths that older people are all alike; that old people have no further contributions to make

to society; that they are all sick, senile and useless; the myths that the aged are alienated from their families. High-risk subgroups in the aging population such as minorities and women have been identified. A good deal has been learned about the special problems of older people in the areas of economics, health, housing, and transportation. Information has been developed about the main concerns of older people and about what contributes to their material and spiritual well-being.

We must recognize that investment in research and training today will ease the social and economic problems our country will face in the 21st century when about 15 per cent of our population will be aged 65 and over. The need to train research and service personnel is now. These persons are the needed teachers of the next generations.

ISSUE: What recommendations are possible regarding the overall amounts which should be devoted to research support?

Discussion. The major federal agencies supporting aging research are the Administration on Aging, the National Institute on Aging and the National Institute of Mental Health. The demand for research funds increasingly has outrun the supply of such funds. The research budget of the Administration on Aging has remained static at $8.5 million from 1977 to 1980 and an actual reduction has been proposed for 1981. Should this reduction take effect, the net effect in the light of inflation would be a de facto cut of 77% in AoA's research budget over the past four years. Unless research efforts refine and hone existing services, and point to new or alternative ones, large scale programs often stagnate. Further, unless service programs are accompanied by independent, objective evaluation, they often operate without consideration of alternative and sometimes

more desirable ways of meeting needs.

In addition to the need for increased evaluation of and research about existing service programs under the Older Americans Act, there is a need for the Administration on Aging to increase the allocation of research funds for investigator-initiated research. Governmental agency staff and their consultants cannot be expected to know all of the important questions which need answers in the effort to meet the needs of older Americans. The limiting of research to those topics specified by agency policy is not conducive to increased understanding of the aging and their needs. Such limitations tend to stifle creativity and effectiveness. Further, governmental agencies are correctly responsive to short-term fluctuations, political and fiscal realities. Research engendered in such an atmosphere may not provide for the long-range continuity which is necessary to answer the difficult questions we face in the future.

Training funds of the Administration on Aging are also shrinking. Paradoxically, billions of service dollars are being spent to carry forward Congressionally authorized programs, but virtually nothing is being spent to insure that the providers have the necessary knowledge and skills.

The National Institute on Aging is a developing Institute, yet to approach its full research and training responsibilities. This agency needs funds that would enable it to fund a substantial proportion of approved research applications; to continue the epidemiological studies identifying at-risk populations such as those suffering from senile dementia; to include women in longitudinal studies; and to provide for special centers of basic research into the mechanisms of aging.

While the numbers of old people increase, the budget of the National

Institute of Aging for training has decreased steadily. The agency supported 177 trainees in 1979, 164 in 1980, and 125 in 1981. How can knowledge be developed in an area, if trained scientists do not exist? Although there may be an overabundance of trained scientists in other areas, the number of trained research scientists in gerontology are still few.

The National Institute of Mental Health Center on Aging receives its research and training monies via allocation from the National Institute of Mental Health. This agency, too, has had no significant growth in its research and training activities. In both areas--research and training--lack of growth seriously discourages new people from entering this field. This occurs at a time when other activities (such as the White House Conference on Aging, The President's Commission on Mental Health, and the Secretary's Committee on Mental Health and Illness of the Elderly) are all trying to stimulate activity in the field of mental health.

Equally as important as adequate budgeting is adequate thought about the direction and purpose of research and training activities related to the aging process and to those other subjects which relate to an "aging" population. The White House Conference process of assessing needed research can help to further understanding of organized fact-finding as an essential component of the "graying" of the American population, together with the vital need for putting such data and analyses at the service of policy makers and program directors.

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A.I.D. #2: HEALTH CARE

CONGRESSIONAL FINDING: "There is a great need to make comprehensive and quality health care more readily available for older Americans."

The fear of huge debt or of bankruptcy from overwhelming medical and hospital bills was a major reason older people and their younger relatives supported enactment of Medicare 15 years ago.

Today, for older people, Medicare has greatly diminished the spectre of catastrophic hospital bills. It also appears that older Americans are now more likely to see physicians than they were in 1966 (Shanas, 1978) when Medicare went into operation.

But the costs of medical care still loom large for the elderly. The latest information available (U.S. Health Care Financing Administration, 1980) shows that during the calendar year 1978, direct out-of-pocket payments by the elderly for health care averaged $608 per person, an increase of 15 percent over 1977 and $371 more than in fiscal year 1966. This upward trend in costs can be expected to continue in 1980, not only because of health care inflation, but also because of increases in the rates Medicare will require beneficiaries to pay for hospital care, skilled nursing home stays, and monthly premiums for the supplementary medical insurance which partially covers physicians' fees.[1]

SHORTCOMINGS IN MEDICARE COVERAGE

ISSUE: What are the implications of having a health care financing

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[1]Effective January 1, 1980, the initial payment for hospital care under Medicare rose from $160 to $180 and daily coinsurance charges for long-term hospital and skilled nursing home stays rose 12.5%. On July 1, 1980, monthly premiums for Medicare Part B rose 9.9% from $8.70 to $9.60.

system for the elderly which is geared to acute care rather than to the prevention and monitoring of chronic conditions? What would be the cost and benefits of expanding Medicare coverage to include preventive and health maintenance services? Can such changes be made within the existing Medicare system or would major new programs (public and/or private) be required?

Discussion. In the view of both professionals and consumers, the Medicare program is not meeting the special health care needs of older people. The Medicare program focusses on providing financial support in the case of acute health problems, particularly those requiring hospitalization. It is chronic health problems, however, which are the major source of disability for older people.

Medicare does not support any of a wide array of noninstitutional preventive or health maintenance services that many feel would help older people to forestall physical deterioration and to maintain independence and a good quality of life. Significant gaps in Medicare coverage include:

---out-of-hospital prescription drugs (yet the elderly consume one-fourth of all drugs purchased in this country) (National Council on Aging, 1978);
---eyeglasses and vision services (it is estimated that there will be a one-third increase in the number of older Americans with severe vision problems within 20 years) (American Foundation for the Blind, 1978);
---hearing aids (29 percent of the elderly report that they have hearing impairments) (Brotman, 1980);
---routine dental care, including dentures (almost half of older persons as compared with less than a quarter of persons of all ages had not seen a dentist within five years prior to 1978) (Brotman, 1980).

Other gaps in Medicare coverage include routine physical examinations, immunizations, foot care, chiropractic care and convalescent care following acute illness.

The Medicaid program for low-income persons of all ages augments Medicare coverage among the elderly poor. Medicaid eligibility requirements,

however, force older people into pauperization before Medicaid can start to pay for their care. Criticisms of the Medicaid program include its imposition of a means test, and the differences between states in the type and levels of health benefits provided and in the eligibility requirements (Corman, 1976). Further, Medicaid payment schedules are so structured as to encourage institutional care even when outpatient care would be suitable.

THE CUMBERSOMENESS OF MEDICARE PROCEDURES

ISSUE: In what ways can Medicare paperwork and processing procedures be streamlined? Can Medicare procedures become more responsive to both the consumer and the health care provider?

Discussion. According to testimony at U.S. Senate hearings, a number of the procedures and policies of the Medicare program appear to limit its usefulness to the consumer. Among the complaints were: steady decline in the percentage of Medicare claims which are processed by "assignment"[2] (only 50 percent in 1979), delays and obstacles in payments, substantial reductions in claims, failure to file claims and to make appeals of rulings, and the complexity and lengthiness of forms and other paperwork required for Medicare processing and payment (U.S. Senate, 1980).

MENTAL HEALTH AND MENTAL ILLNESS

ISSUE: What programs and policies can be introduced to make mental health services accessible to all older Americans?

Task Forces at a 1979 National Conference on Mental Health and the Elderly sponsored by the U.S. Select Committee on Aging recommended eliminating discriminatory treatment of

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[2]Procedure by which doctors accept Medicare payments (set by HHS) as their full fee.

mental health services under Medicare, providing 80% Federal matching for State support to CMHCs and mandating a comprehensive planning and coordination of all relevant Federal programs, including Medicare, Medicaid, Title XX (of the Social Security Act) and the Older Americans Act (U.S. House, 1979). Should corrective action be taken to implement these recommendations?

Discussion. Older adults have been identified as underserved by mental health practitioners. In 1977, an HEW Secretary's Committee on Mental Health and Illness of the Elderly stated:

> The demographic implications . . . are profound. Not only is the population 65+ growing at approximately twice the rate of the general population, the age group 75+—those at highest risk--is increasing at an even faster rate. By the year 2000, persons 75+ will make up nearly 45% of the older population (U.S. Dept. of HEW, 1979b, p. 41).

Less than two percent of Medicare dollars go into mental health coverage for elderly and disabled beneficiaries, and only a little over one-tenth of one percent of these dollars reimburse the community mental health centers (CMHCs) for both patient and ambulatory care. CMHCs have been criticized as being reluctant to serve older persons (U.S. Civil Rights Commission, 1977). These centers are required by law to make the elderly a special target group. Medicare policies on mental health coverage undoubtedly contribute to the uneven performance of CMHCs on behalf of the elderly. Under Medicare, "outpatient reimbursement for mental health care is severely restricted, thereby forcing a number of otherwise unnecessary hospitalizations" (U.S. Dept. of HEW, 1979a, p. 14). Medicare is geared primarily to institutional care with little support for outpatient services (Krueger, 1977).

ISSUE: Should increased efforts be made through research to determine the causes and effective treatment of mental health problems in late life?

Discussion. Little is known about the cause or effective treatment of many of the mental and emotional disorders which occur in later life (Storandt et al., 1978). The task forces which met at the 1979 National Conference on Mental Health and the Elderly recommended appropriation of $20 million per year for the study of "senile dementia" and $10 million per year for research on the causes and treatment of depression in the elderly (U.S. House, 1979).

The Task Panel on the Elderly of the President's Commission on Mental Health (U.S. Dept. of HEW, 1979) recommended a comprehensive program of research on brain diseases in late life. The Task Panel stated:

> The new knowledge obtained through research is the ultimate service and the ultimate cost container. Without new knowledge, we will just keep on doing the same things in the same ways, at every (sic)-increasing costs. We will continue to warehouse older people in nursing homes instead of preventing the conditions that brought them here (p. 21).

HEALTH CARE DELIVERY AND THE TRAINING OF PERSONNEL

ISSUE: What policies should be instituted to provide for the training of health care providers to meet the increasing need for qualified personnel to deal with the various health care needs of the elderly? Should there be changes in the content of physician education specifically focussed on the needs of the elderly? If so, how can these changes be implemented?

Discussion. The elderly need a comprehensive, integrated, easily accessible system of health care. One HEW assessment of organizational shortcomings (Califano, 1978) said that such a system would include:

---Adequate supervised residential facilities for those who lack families but want to live in their communities.
---Special services for those who live at home but need outside help; for example, transportation or shopping help; or help with meals or with personal care.

---A range of alternatives between the hospital and the nursing home, including a system of home health care.
---Innovative and compassionate ways of caring for the terminally ill outside the traditional hospital or nursing home.

"It is easy enough to describe such a system," said the HEW analyst, "but it is nowhere to be found. We have, instead, a confusing and expensive patchwork of financing systems that create an even more inadequate delivery system."[3]

If there is to be a marked change in Federal policy from the present emphasis on institutional care to community-based systems offering a range of noninstitutional resources, there will also be a need to train many categories of health care personnel to serve older people. Further, as the population ages there will be an increasing need for physicians' assistants, nurse practitioners, speech and hearing specialists, dentists, home health aides, physical therapists, et cetera, with special training in gerontology and geriatrics. Some professionals recommend that to provide effective and humanistic health care, service providers must be taught to instruct older people in self-help for prevention of illness and for health maintenance. Others cite the importance of developing standards for licensing and certification of health care providers to ensure quality health care for older people.

In the last few years increasing attention has been given to the introduction of geriatrics into the medical school curriculum. A report issued in September 1978 by the Institute of Medicine (U.S. National Academy of Sciences, 1978) recommended:

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[3]Additional discussion of this delivery sytem will be found in AID #5, Long-Term Care.

> That medical schools should include appropriate content on aging in basic and clinical science courses and favor the establishment of a complementary required course that integrates knowledge about aging and the problems of the elderly;
>
> That preparation for care of the aged be included in clinical clerkship and in housestaff training programs, as well as in examinations for certification and licensure;
>
> That nursing homes and other long-term care facilities be included in clinical rotations for medical students and housestaff. Experience with home health programs and other alternatives to institutionalization is also desirable . . . .

A Rand Corporation study (reported in the New England Journal of Medicine, June 20, 1980) projected a great need not only for instructing all physicians in health care of the elderly, but also for an emphasis on geriatric specialists for the remainder of this century.

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A.I.D. #3: HOUSING AND HOUSING SERVICES

CONGRESSIONAL FINDING: "There is a great need for expanding the availability of suitable and reasonably priced housing for older individuals, together with services needed for independent or semi-independent living."

A serious examination of the housing needs of the elderly must focus on (1) the availability, quality, and cost of owner-occupied homes and rental housing; (2) the interrelationship of older people with their neighborhoods and communities; (3) the accessibility of housing-related services; and (4) the role research and education can play in improving living conditions for older people.

If housing policy is truly to meet the needs of the diverse elderly population for a good quality of life, it must take into account the variety of living preferences older people may have. Freedom of choice may be the key principle underlying the most effective housing policy. One specialist in research on housing explains:

> "Currently, planned housing in its usual age-segregated form meets the needs of a substantial number of elderly, but the majority prefer continued residence in 'normal' communities. Because of this majority's preferences, it is clearly time for our previous disproportionate emphases on planned housing for the elderly to become balanced with proportionate concerns for those who wish to maintain their lifestyle in ordinary communities (Lawton, 1978)."

According to another authority:

> "the goal of 'freedom of choice' therefore means that no monolithic housing policy which emphasizes only a limited range of alternatives will be acceptable (Pastalan, 1980)."

OWNER-OCCUPIED HOUSING

ISSUE: What strategies might be employed to help the elderly stay in their homes and to maintain these homes in good physical condition for as long as possible? How can resources be

concentrated on the low-income group while still minimizing the negative features of establishing income eligibility?

Discussion. Because 70% of older heads of households (and 82% of all elderly married couples) own their own homes (Welfeld and Struyk, 1979), assisting this group should be a top national priority.

At present there is no integrated structure through which older homeowners with fixed incomes, few assets, and deteriorating properties may obtain assistance to maintain their own homes while at the same time preserving the quality of the neighborhood where they are located. In a study recently done under an Administration on Aging grant, Lawton and Benner (1980) estimated that there were at least two million low-income older people with major needs for home repairs. The federal programs providing such assistance—the HUD Community Development Block Grant program, Title III of the Older Americans Act, Title XX Social Services, the HUD Section 312 Rehabilitation Loan program, and the Farmers Home Administration Section 504 grant program--are presently meeting only a small fraction of this need. The greatest need for such assistance is among the low-income elderly, who are disproportionately found among some minority groups and in small-town and rural areas.

Non-physical housing-related services

Even though 75 percent of elderly homeowners may possibly be able to pay for their home maintenance, a variety of factors such as lack of information, fear of unscrupulous entrepreneurs, unfamiliarity with bureaucratic procedures, and other barriers may prevent them from taking the most effective action in their own behalf. As Pastalan (1980) suggests, service programs that provide older people with housing counseling, information,

and active assistance in relocation or management and disposition of property may enable them to make more appropriate choices in maintaining fulfilling living situations. "Service programs providing homemaker services, delivered meals, and special transportation enhance the ability of the elderly to maintain independent or semi-independent living."

Other assistance programs

Some other programs of potential assistance include:

1. "Circuit breaker" property tax relief whereby relief is given on a graduated scale according to income. The effectiveness of such programs is uncertain, however, and needs further testing.

2. Reverse mortgages that allow older homeowners, while maintaining residence, to use home equity for supplementary income for a given period. The Federal Home Loan Bank Board in December 1978 authorized savings and loan associations to begin offering a number of new mortgage instruments, including reverse mortgages (U.S. Senate, 1979). Important questions still remain, however, on how reverse mortgages can be made acceptable to homeowners.

3. The participation of the private for-profit sector in home rehabilitation and maintenance. Such participation is relatively small at present. Incentives to enlist this all-important element in behalf of the elderly homeowner need to be designed and tested.

RENTAL HOUSING

ISSUE: Rental housing and subsidies for rental housing threaten to decline in magnitude. What alternative arrangements can be made to provide subsidies, supports, and more effective housing-related services for older people in rental housing? How can older renters be protected against displacements by urban revitalization, condominium conversions, and other public and private actions?

Discussion. The poor, minorities, and unmarried persons are over-represented among the 30 percent of the population who live in rental housing. Although federal programs have been concentrated in rental housing, the great majority of older people who are renters occupy open-market housing. As documented by the U.S. General Accounting Office (1979), the national vacancy rate for such housing is now below 5 percent, the lowest level since the Census Bureau began tabulating such rates 25 years ago. Twenty-six million families are now in rental housing; the 15 million families with incomes below $10,000 annually will suffer the most from the decline in the availability of such housing. A major national apartment loss is part of a trend caused by the production of fewer new rental units, abandonment and foreclosure of older apartments, the return of the upper middle class to "regentrified" neighborhoods and the conversion of desirable rental units into condominiums or cooperatives. Low-income older renters are among those hardest hit by these changes (New York Times, 1979).

New approaches may be needed to insure an adequate supply of low-cost rental units to the elderly. Section 8 of the Housing and Community Development Act "provides rental assistance under which moderate and low income persons pay no more than 25%, and as low as 15%, of their incomes for rent in newly constructed or substantially rehabilitated dwellings" (U.S. Senate, 1980, p. 216). According to Welfeld and Struyk (1979), 500,000 of the 1.2 million persons who have received Section 8 assistance have been elderly or handicapped. In terms of older persons served, the Section 8 rent subsidy program has major significance because about 1.7 million elderly pay excessive portions (over 35%) of their incomes for housing. However, as rental costs in dwellings occupied by older people rise rapidly, so does the

cost of the Section 8 program and Federal funds are strained.

Planned rental housing

ISSUE: How can private nonprofit, public, and for-profit sponsors be encouraged to continue developing planned housing and to improve its design and management?

Discussion. In 1971 one goal of the White House Conference on Aging was the production of 120,000 new planned housing units for the elderly annually. This goal has not been reached. Even had it been reached, it would not have met present need, and it would still fall short of foreseeable future need. Public housing and the Section 202 direct loan housing programs are widely accepted and require continuation. Congressional support for the Section 202 program, for example, has grown markedly since the 1971 White House Conference. This program has resulted in a high degree of community participation and planning by eminent nonprofit sponsors and their associates. There is continuing need for traditional public housing, as well as incentives for private developers to upgrade the quality of planned housing built under the Section 8 new-construction program.

Planned housing with services

ISSUE: How can a variety of different needs be accommodated in congregate housing: an optimal match between tenant need and service, the concerns of both local housing providers and the aging network, and the cost effectiveness of such services?

Discussion. Congregate housing for the elderly is:

". . . an assisted independent group living environment that offers the elderly who are functionally impaired or socially deprived, but otherwise in good health, the residential accommodations and supporting services they need to maintain or return to a semi-independent lifestyle and to prevent premature or unnecessary institutionalization as they grow older . . . ." (Donahue, Thompson, and Cumen, 1977)

Congress, in Section IV of the 1978 Housing Act ("Congregate Housing

Services Act of 1978") has provided a vehicle for provision of services on a demonstration basis to a limited number of vulnerable residents in public and 202 housing. The need for increased services is apparent as the 700,000 people already in planned housing age in these environments. A similar demonstration is underway by a joint Administration on Aging-Farmers Home Administration project at 10 congregate housing sites in rural settings.

COORDINATION OF COMMUNITY RESOURCES

ISSUE: How can resources within the local neighborhoods be mobilized so that a sense of involvement by residents of all ages, aging and housing services, commercial entities, and financial and banking interests is engendered?

Discussion. Planning for housing-related services must be done on a neighborhood or community level. To be successful, this process requires the aging network and the housing network to pool resources and expertise. Just as important, the public and the private sector also must join forces. Enlistment of the elderly, and others, in acceptable community development programs will broaden the base of concern and participation. Approaches to coordination might include:

1. The integration of social and housing-related services in a neighborhood-based program. A Mutual Help for the Community Elderly Demonstration Project in Benton, Illinois is not a housing project per se. It is a process with "an emphasis on neighborliness, as well as neighborhoods," thus helping to provide an organizational opportunity to both providers and recipients of services (Ehrlich, 1979).

2. Experiments in living arrangements. In "house-sharing" the owner of a private home may decide to renovate and rent to one or more older persons who have mutual and private space in the redesigned structure. Othe

forms of assistance in shared living by two or more individuals include help from an agency locater and screening service, cooperative living arrangements involving the purchase or rental of apartments or residences for group living, and small-group congregate residences with high levels of support. These offer ideal opportunities for the integrated delivery of housing and social services, they use existing housing stock, and they encourage people to remain in familiar neighborhoods.

3. Assistance from the Neighborhood Reinvestment Corporation (formerly the Urban Reinvestment Task Force), which in a little over 5 years has evolved from a demonstration program to a permanent entity. Its assistance is instrumental in developing local, public-private resident partnerships to enable low-income older persons to rehabilitate existing quarters or become new homeowners in previously decaying areas (Urban Reinvestment Task Force, 1979).

RESEARCH ON HOUSING-RELATED TOPICS

In addition to research topics already suggested by the preceding text, it is recommended that considerable attention be given during the White House Conference process to promoting research in several different areas.

Several specific research needs can be identified:

1. The existing living space of older people between the ages of 65 and 75 should be analyzed in terms of safety, needed redesign, and cost effectiveness with respect to providing living space for these people as they become older and more frail.

2. Research is needed on the potential housing problems and service needs of older people in areas where they will be more concentrated during

the next decade, for example, in suburbs, inner cities, or retirement areas of the country.

3. Some segment of the older population fails to make needed housing adjustments because of personal or environmental, rather than economic, barriers. Study is required of how counseling and other personal supports can assist older people in making housing decisions and taking actions such as selling, buying, moving, remodeling, repairing, and so on.

4. Very little is known about the qualities of effective management in planned housing, particularly how the goals of sensitive personal relations, optimal service planning, and effective financial management can be achieved simultaneously.

EDUCATION AND PERSONNEL NEEDS

There is a major need to provide educational opportunities for planners, designers and leadership in finance and business and in housing agencies so that they may best deal with the changing housing needs of older people. One thrust must be to train managers and social service providers in the approaches necessary to keep older people in independent or congregate housing situations as long as possible. Training is needed in the design of new housing, the rehabilitation and revision of existing housing, and the use of sheltered housing, group housing and foster home care.

Such educational efforts are required at 3 levels:

1. In the curricula of colleges and universities where people about to enter any of these relevant occupations are being trained.

2. In specialist programs where students are undergoing training explicitly to work with or design for the aged.

3. In the continuing-education arena, where thousands of designers, administrators, service-agency personnel, and private-sector employees could become better-equipped to work with their elderly clients.

# # # # #

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A.I.D. #4: SOCIAL SERVICES

CONGRESSIONAL FINDING: "There is a great need for a more comprehensive and effective social service delivery system for older individuals."

Fundamental questions about the future of social services for older persons must be brought forth throughout the White House Conference process, in the hope that the decade following the 1981 Conference will be marked not only by response to fairly short-term considerations in this area but also by progress to more clearly defined goals for the social services. Such services must be considered in relation to the impact of the Older Americans Act upon program operations and the elderly.

The Older Americans Act became law in 1965. At first, it was a modest Federal-state partnership in which state agencies were given considerable leeway in funding projects which were usually the result of local initiative. In 1971, the year of the most recent White House Conference on Aging, the Administration request for the entire Act--including services, training, and research--was under $30 million.

In 1980, the Older Americans Act is funded at well past the $500 million mark. At the same time, a nationwide "network" of state agencies and almost 600 area agencies and close to 12,000 nutrition sites (AoA, 1980) are engaged in a common effort to make services to the elderly widely available. The Older Americans Act has been criticized by those who say it does too much and thus discourages traditional sources of social service, by those who say it fosters a cruel delusion by appearing to promise more than it can deliver (Binstock, 1978), and by those who say that it is deliberately ambiguous and unlikely to foster

self-determination among the older Americans it is meant to serve (Estes, 1979).

Within the Congress, strategically-placed legislators also have asked whether the Older Americans Act can achieve all that is called for in its legislative charge. As a result, a certain amount of revised "targeting" of services was written into the 1978 amendments. Additional evidence of the concerns of Congress is indicated in the list of issues related to the Older Americans Act that the Federal Council on the Aging is mandated to examine. The Council is required to make:

> "a thorough evaluation and study of Older American Act programs, including:
>
> "(A) an examination of the fundamental purposes of such programs, and the effectiveness of such programs in attaining such purposes.
>
> "(B) an analysis of the means to identify accurately the elderly population in greatest need of such programs; and
>
> "(C) an analysis of numbers and incidence of low-income and minority participants in such programs."

In addition, the Council study is permitted to include:

> "(A) an exploration of alternative methods for allocating funds under such programs to States, State agencies on aging, and area agencies on aging in an equitable and efficient manner, which will accurately reflect current conditions and insure that such funds reach the areas of greatest current need and are effectively used for such areas;
>
> "(B) an analysis of the number of non-elderly handicapped in need of home-delivered meal services." (Public Law 95-478, October 18, 1978)

For the purposes of this Congressionally-mandated study, the Federal Council has divided Administration on Aging programs into four major groups: national policy development and issues advocacy, community services system development, financing social and nutrition services for the elderly, and applied research demonstration, evaluation, and education.

The Council is also reviewing all prior evaluations and studies and has already issued some preliminary findings (Federal Council, 1980).

The 1978 amendments to the Older Americans Act extended its authority through 1981 and established a 3-year planning cycle to replace the former 1-year cycle. Thus, proposals and deliberations about the next extension of the Act will take place during the preparations for the White House Conference, while at the same time many of the innovations in the 1978 amendments will have been only recently activated. A reasonable amount of time is needed to determine the efficacy of the changes made in the 1978 legislation and also to absorb a considerable amount of study information now being developed.

Arguments against abrupt change in the mission and principles of the Older Americans Act include the following:

1. The Federal-state working relationship incorporated into the Act from the very beginning has provided learning experiences and channels of communication which, given adequate evolutionary development and direction, could continue to contribute to the well-being of older Americans and could provide a model for service programs for other age groups.

2. The 1978 amendments gave the Administration on Aging important new emphases and responsibility, including: more direct involvement in inter-agency consultation and action on health matters, particularly in long-term care (to be discussed further in A.I.D. #5); advocacy review of actions by other Federal agencies (a similar requirement was imposed on state and area agencies on aging); and new administrative guidelines including the merging of social services and meals delivery under one new broadened title; the defining of conditions of acceptability for "focal

points" of community-based service delivery; and the overseeing of new allocations of funds required at the area agency level (50 per cent of such to be expended on services associated with access, in-home services, and legal services). In addition, the AoA Commissioner is instructed to develop a new National Manpower Policy for federal programs related to aging and to update this plan every two years.

ISSUE: Is the present system of service delivery to the elderly effective? What is the impact of the current fragmentation of programs upon the delivery of high quality services? How many older adults "fall between the cracks" and receive no services at all? Do the services reach people in the most need, do they fairly serve minorities and the poor?

Discussion. Too often older adults are denied services because they do not fit criteria established by the service delivery agency. Even the professional gerontologist is hard-pressed to keep informed about new and changing programs, agency rules and regulations, and the types of services available. Research is needed to determine who among the elderly receives what type of service and what factors influence the delivery of these services. Further, research is needed to determine the extent of knowledge about these services among older adults, their families, and professionals. Extensive research and development is required to determine more effective alternative means of service delivery which will eliminate, at least to some extent, the frustrations and inhibitions which now arise from fragmented service programs.

ISSUE: Under the present legislation, the Administration on Aging is authorized to offer a wide range of services (listed below). If it offers all of these, can it offer them adequately? If it offers services selectively, can the needs of all elderly be met?

Discussion. The range of services authorized under Title III of the 1978 amendment includes, but is not limited to, the following:

---health, continuing education, welfare, information and referral, recreational, homemaker, counseling;
---transportation to nutrition sites or to social and health services;
---outreach to encourage older persons to use the services and resources available to them;
---services designed to help older persons find or maintain adequate housing such as residential repair and renovation projects which help meet housing standards or adapt homes to meet the needs of impaired older residents;
---services to help vulnerable elderly persons avoid needless institutionalization by providing for preinstitutional evaluation, home health care, homemaker services, shopping, escort, reader and letter writing services, and other forms of support services that make it possible for more frail older persons to continue living independently in a home environment;
---services to provide legal and other counseling assistance such as tax and financial counseling and to provide information about or protection of older persons' rights and benefits;
---services to help older persons maintain physical and mental well being;
---health screening to detect and prevent illness, especially those that affect older persons most often;
---preretirement and second career counseling for older individuals; and
---State-level ombudsman services for residents of long-term care facilities. (U.S. Administration on Aging, 1980, p. 75)

Clearly, not every item listed above is of equal importance to entire populations of older persons, but for any individual some one among these items may be especially important. Asked at a hearing whether Older Americans funds could better be directed at a few key needs, rather than a whole gamut of them, the U.S. Commissioner of Aging said:

> In a way, it is sort of like saying . . . we only have so much funds; do we want to teach first grade children how to read; do we want to teach high school seniors physics; do we want to teach college freshmen literature, postgraduate students research methodologies? I'm afraid that what we are talking about is providing a set of services that relate very basically to quality of life, an ability to live decently (Benedict, 1978).

A differing view lists these deficiencies of the Older Americans Act, as identified by Dr. Robert Binstock in testimony at an earlier,

Congressional hearing and summarized in a Senate report (Senate Committee on Aging, 1979):

---Funding distribution so thin as to have little impact on any given problem.
---The 'illusion' that a variety of problems can eventually be solved through funding and implementation under the Older Americans Act.
---The bureaucratic components of the network--the public and voluntary service agencies and the universities and the colleges--have quite understandably become preoccupied with sustaining and expanding the different, thinly funded program elements with which they are directly involved.

ISSUE: If services become too closely identified with public bureaucracies of any kind, will they reach fewer, rather than more, persons because of the damage they may do to the "informal support system" (family members and friends who, as many studies have shown, now provide the bulk of help needed by older persons in their residences)?

Discussion. This question has as many answers as there are successes and failures in prior experience. A balanced appraisal, based on a cross-national research effort, dealt with more generic services than those provided under the Older Americans Act, but it provided a helpful principle of "shared functions" in which representatives of bureaucracies (described in this work as an honorable, if hardpressed sector of society) performed specialized and essential routine services while family and friends perform more sustained and personal services;

> There is no reason why bureaucratic organizations serving the elderly cannot perform the uniform tasks for which they have been specifically organized, and why primary groups such as families cannot perform and perform well the non-uniform tasks to which their structures are most suited . . . . There is a need for increased sensitivity to clients and a willingness to listen on the part of human service systems and their functionaries. Listening and communicating are the beginnings of much more effective and coordinated relationships. The promise of a more symbiotic and balanced exchange between primary groups and bureaucratic organizations serving the elderly is predictable. In our judgment such a development in the coming decades can only improve the quality of life for the elderly person who needs both the bureaucracy and the family to enhance his survival and life style (Shanas and Sussman, 1977).

ISSUE: Will older Americans ever fully accept social services originated under official auspices, or will they be more likely to respond more positively to goals and activities which they themselves have established, probably with assistance from Federal and state funding sources, but guided primarily by their own appraisal of community needs?

Discussion. Older people are now limited under Federal policy to advisory roles in Older Americans Act programs. One analysis states that this policy prevents "the elderly from playing a decision-making role in the programs and policies supposedly created for their benefit. These barriers, present in policy designs from the start, have been raised even higher by the various agencies charged with implementing programs for the elderly" (Estes, 1979).

It is interesting to note that in a number of states, close working relationships have developed among state agencies on aging, state legislative units and "senior citizen" organizations, as attested by special legislative days on aging and even by "Silver-Haired Legislatures" in Florida and elsewhere. Perhaps the closest relationship is in Colorado, where a statewide Congress of Senior Organizations cosponsors publication of a news report with the state agency on aging, and where, in cooperation with area agencies on aging, the same organizations recently conducted 17 "Aging Advocacy Workshops" in all regions of the state. More than 600 leaders of senior groups and other aging advocates attended (CCSO Alliance, 1980). (The Benton, Illinois, Mutual Self-Help project mentioned in the Housing A.I.D. #3 also advances important concepts.)

ISSUE: Should the Older Americans Act continue as a "categorical" program intended to serve older Americans past age 60, or does the existence of an entire service network devoted to one age group inhibit the development of a service network serving all ages in what is rapidly becoming an "age-irrelevant" society?

Discussion. Criticisms of categorical programs for single age groups are continuing, but defenders of such programs such as former Commissioner of Aging (and former Health, Education, and Welfare Secretary) Arthur Flemming have maintained that an unspecified period of specialized concern to the service needs of the elderly is needed to develop a truly responsive service network for older Americans. Historically the needs of the elderly have been a low social priority, and there is no reason to assume these needs would receive sufficient attention if they were not specifically singled out for attention.

Another view would considerably shorten the waiting period for specialized programs:

> . . . the existing framework should not be fully developed, but preserved as a structure to link older persons effectively with the larger generic service system. Prior to the development of the network, older persons had poor access to the service system and got little response when they did reach it. The network has now sufficiently developed to provide an effective focal point through which older persons can enter the system. And generic agencies will likely be far more responsive to the aging than in the past because, with the shrinking size of the clientele for youth services, many generic agencies will need the growing population of older clients as a justification for staying in business (Binstock, 1979).

Still another consideration is advanced by an authoritative researcher and analyst who has contributed considerably to an understanding of the differences among generations in the last third of life:*

> In a society in which age is becoming increasingly irrelevant as a predictor of lifestyle or as a predictor of need, policies and programs formulated on the basis of age are falling increasingly wide of the mark; income and health care and housing and other goods and services should be provided, not according to age, but according to relative need (Neugarten, 1979).

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*It is commonly noted by other gerontologists that there are more physical differences among older persons than among any other age group and that these differences increase as age increases.

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A.I.D. #5: LONG-TERM CARE

CONGRESSIONAL FINDING: "There is a great need for more comprehensive long-term care policy responsive to the needs of older patients and their families."

Long-term health care is "the professional or personal services required on a recurring or continuous basis by an individual because of chronic or permanent physical or mental impairment" (U.S. Dept. of Health, Education and Welfare, 1979). Impatience at what is usually called a "non-system" of long-term care/support[1] for persons with chronic disabilities was expressed at the 1971 White House Conference on Aging[2] and has been echoed with growing intensity since then by government, gerontologists, care providers, and the press.

The ratio of medically-oriented service expenditures (including doctor's bills, hospitalization, and nursing home treatment) to health-social service expenditures for the long-term support of the health of the elderly may be placed at 30 to 1 (S. Brody, 1979). Nursing home costs rose from $1.27 billion in 1965 to $10.6 billion in 1976. Nursing home beds, now at the 1.3 million level, exceed acute care beds; the Congressional Budget Office has predicted that the number of skilled nursing beds will rise to the 2.5 million level within 5 years if current trends continue.

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[1] A long-term program to serve the chronically disabled must involve elements of both support and care (S. Brody, 1979). This framework has as objectives: prevention, modification, and maintenance.

[2] A section on health called for a "coordinated delivery system. . . to assure continuity of both short- and long-term care for the aged." A long-term care Special Concerns session proposed a federal uniform level of benefits and standards for institutional care and recognized that "long-term care involves not only in-patient care but services to people in their own homes."

Widespread dissatisfaction with the present national commitment to institutional care provides a compelling reason for the 1981 White House Conference to consider the need for a coordinated approach to long-term care/support in which institutional and noninstitutional components of the system may be balanced. Institutionalization is the most extreme response to serving the functionally-disabled elderly. It has been suggested that the continuum of care be an organizing concept for a system of sevice delivery. There could be a whole continuum of support services--medical and social--which would allow home-based and/or community care for most elderly and institutionalization for the proportion of older people who need it.

Federal agencies have recently acknowledged the need for a systems approach to the development of long-term care support, rather than the existing piecemeal approach. The Administration on Aging and the Health Care Financing Administration have recognized the need to take unified action to stimulate system level changes in the delivery system, in the relationship among service providers, and in the way long-term care dollars are allocated. In addition, these two agencies hope to create structures for coordinating, managing and delivering services to the functionally-disabled elderly at the community level and to collect comparable information across demonstration projects to help in planning agency policy (Federal Register, 1979).

Communication and coordination problems often arise due to the lack of a standard nomenclature in the field of long-term care (Kerschner and Cote, 1979). Long-term care usually suggests a medical or institutional orientation when it should include the whole continuum of care. Other problems result from the use of varied terms to identify similar facilities and similar terms to describe varying facilities.

An example of confusing terminology is that the terms nursing home, proprietary home, foster home, a senior residential facility may incorrectly denote the same kind of institutional service creating confusion among reimbursement authorities, planners and consumers.

ISSUE: In the area of health planning, are health systems agencies sufficiently focused on the continuum of care or are they reinforcing the prevailing emphasis on medical and institutional long-t ~ care services?

Discussion. Health planners in this nation should not assume that planning which focuses solely on institutional beds is adequate. Health systems agencies, given the responsibility to assess needs and to avoid duplication and waste in meeting those needs, have the following challenges in communication if they are to be fully informed and responsive:

> While the task of planning for a long-term support/care system is within the orbit of the Health Systems Agency, it nevertheless requires the cooperation of a number of other planning organizations who are concerned more specifically with special target populations and with particular service areas of the system. The Veterans Administration, the Area Agencies on Aging and the Community Mental Health and Retardation Centers are three that have been identified as having specific target population interests that are mandated by law. It is in the area of housing services that the HSA may have some difficulty in justifying a priority of interest, although these resources are an intimate part of a long-term support/care system. Local housing and redevelopment agencies, as well as local governmental systems who have zoning purviews, are likewise significant in planning for a housing support system for the aged and disabled. State agencies concerned with licensing, development and support of surrogate family arrangements are also involved.
>
> Beyond the housing resources, there are other vital complementary services, such as senior citizen centers, legal services and protective services which may be perceived as tangential to a health interest. The HSA, then, must involve a number of other groups in formulating a complete long-term support/care system (S. Brody, 1979b).

In addition to the above resources, public health departments may be in a position to assume an increasing role vis a vis the chronically ill population.

(Note: Attachment 1 provides a schematic representation of components

of a long-term care/support system and gives further insight into the variety of agencies and programs involved.)

ISSUE: Might Health Maintenance Organizations (HMO's) be viewed as one option for providing the long-term care/support services of older people? Does the present system of Medicare reimbursement discourage participation of older people in HMO's?

Discussion. HMO's are group practice, pre-paid plans which offer comprehensive health care services including prevention, maintenance and treatment of chronic and acute conditions. The Medicare reimbursement system, on the other hand, offers payment for individual services rendered and has limits on the types of services which are reimbursable (see AID #2 on health care for a discussion of services not covered under Medicare).

ISSUE: Should Federal policy emphasize in-hoem health and social services as a component of the long-term care/support system?

Discussion. A recent HEW report notes that:

> Available data suggest there may be a substantial need for in-home personal support services. Three to five percent of the total noninstitutionalized population (12 to 17% of the elderly) are either bedridden or require assistance in the basic functions of daily living. Yet, significantly, only about one-third of the functionally disabled receive some form of governmental assistance. Further, the elderly population with the highest level of functional disability, will more than double between 1977 and 2035.
>
> When in-home personal support needs are met, there is considerable evidence that more costly and debilitating institutionalization can be avoided. In fact, figures indicate that assistance from family and friends is the major alternative to institutional admissions (U.S. Dept. of Health, Education and Welfare, 1979a.)

Further exploration should be made of the implications of the finding by a General Accounting Office Study (Comptroller-General, 1977) that in-home care by family is more economical and efficient than institutional placement up to a certain point of disability of the elderly individual receiving the help.

Problems with existing programs were described in the same report:

"---Overlapping program constituencies.
---Substantial differences in service definitions and the range and duration of services covered.
---Distinctions made between 'health' and 'social' services which reinforce fragmentation of service provision to those in need.
---Varying program regulations and reimbursement methods.
---Different Federal, State and local relationships between programs."

ISSUE: What can be done to provide assistance to family care-givers and incentives for in-home care?

Discussion. With increasing numbers of older people requiring some king of care and support, policy planners will be compelled to look at the ability and willingness of family members to provide in-home serivces.

Presidential advisor Harold Sheppard describes a growing problem:

> The proportion of Americans in the early sixties who have older parents and relatives still alive is increasing at a dazzling pace. In 1960, there were 46. But by 1990 that number will climb, to at least 63, and by the year 2000, the proportion of very old persons--relative to those 60-64--will be at least 79 per 100, assuming no further progress in the biomedical sphere . . . . Can we really expect an increasing proportion of Americans in their sixties to take care of their elderly relatives--if they themselves are retired? Assuming they had the skills required--and love is not enough--what about the costs involved? (Sheppard, 1978)

Elaine Brody describes yet another problematic dimension of caregiving:

> Women who are the primary providers of services to older people are often "women in the middle" in many senses; they are in middle age; they are in the middle from a generational standpoint; and they are in the middle in being subjected to multiple and often competing demands. In addition, they may be "in the middle" in experiencing conflict due to changing social values, that is, the value of doing out-of-home work vis-a-vis the traditional value that care of the elderly is a family responsibility. Such middle-aged women may be emerging as a new high-risk group in our society. The multiple pressures and the stress they experience can affect negatively their capacities to continue their high level of service to older people (E. Brody, 1979).

ISSUE: What are the factors which influence an individual's response to health problems in later life and acceptance of health care for chronic health problems?

Discussion. More investigator-initiated research is required to determine the factors which determine the individual's response to

health problems and their treatment. Little is known about compliance, decision-making, family roles, and adaptation to chronic health problems among older adults. What are the preferences for types of care and how do they vary by demographic and geographic factors? These are but a few of the research questions which must be addressed in the future.

ISSUE: In what ways can policy-makers insure adequate numbers of trained personnel to deliver long-term care/support services?

Discussion. The provision of an array of services requires a cadre of specialized personnel. Acute care has dominated the educational system in the past 30-40 years. It is clear that the area of long-term care is the least developed from the standpoint of education of health care professionals. A report by the National Academy of Sciences (1978) urges that long-term care programs be included as part of the training programs of medical students and physicians. Additionally, long-term care settings allow for collaborative efforts between multiple health professionals in a way not generally possible in acute care settings. Thus, physicians, nurses, social workers, and allied health professionals can collaborate in the "team approach" in an effective way for the care of the patient.

To ensure quality care, salaries in long-term care facilities and other health agencies will have to catch up with salaries in acute care facilities. Licensed professional staff in such facilities continue to receive salaries below those of their counterparts with equal education working in acute hospitals. In California, most certified nurses aides in long-term care receive only 20¢ an hour above minimum wage. Turnover rates in nursing homes are as high as 60% (Cunningham, 1979) leading to serious difficulties with continuity and quality of care. While home care is urged as a long-term care option, well-trained home health aides, visiting nurses and homemakers are all in short supply in many areas of the country.

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A.I.D. #6: EMPLOYMENT OPPORTUNITIES

CONGRESSIONAL FINDING: There is a need to promote greater employment opportunities for middle-aged and older individuals who want or need to work.

One of the key deterrents to a genuinely "age irrelevant" society is the ingrained "one-career trajectory".[1] Today the average person's life is divided into a period of preparation for employment (usually through formal education), a work period (usually characterized by growing expertness and upward mobility in a single career path), and a time of retirement from that career.

This pattern is under challenge. One of its critics points to the development of a fluid life cycle in which role transitions occur frequently and often without reference to chronological age:

> The society is becoming accustomed to the 70-year-old student, the 30-year-old college president, the 22-year-old mayor, the 35-year-old grandmother, the 50-year-old retiree, the 65-year-old father of a preschooler and even the 85-year-old mother caring for her 65-year-old son. Age norms and age expectations, then, are diminishing in importance as regulators of behavior and in this sense, too, we are creating a society in which age is losing its relevance (Neugarten, 1979).

Such shifts in age norms are harbingers of other, more widespread changes likely to occur in the next few critical decades of the "graying" process for this nation's population. For today's and tomorrow's middle-aged and older workers, much depends on how well these changes are made.

We cannot continue to waste the talents of "millions of trained

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[1] This term appears in the report of the Committee on Evolving Roles and Careers in the Future Society (Margaret Hickey, Chairman; Gordon F. Streib, Organizer, at a Symposium on White House Conferences as Agents of Social Change, Reston, VA, 1979).

accommodating their desires for more flexible work schedules. As employers take a positive approach in which they recognize the worth of their older employees, the ultimate result will be wider opportunities, and more cooperative relations among different age groups (Testimony, U.S. Senate, 1978).

The Secretary called upon employers to offer a "full menu of options" for the older employee, including:

---Continued full-time work;

---Regular part-time work;

---Temporary callback;

---Community work.

ISSUE: Is the Federal Government a model employer in developing and offering the options described by Secretary Marshall? If not, how can the White House Conference process be of assistance in focusing attention on the possibilities for action and means of achieving it?

Discussion. Among the difficulties in arriving at improvements in work arrangements for older workers are those described in a landmark Department of Labor appraisal (Chapter 4, Employment and Training Report, 1978), for example:

---Emerging industries may recruit or require workers, typically from younger age groups, but more than half of the employed men aged 45 and over in 1970 were concentrated in declining or slow-growth industries.
---Limited educational attainment hampers many older workers.
---Population survey data for 1976 show that over 60 per cent of the 45- to 54-year-old male nonparticipants in the labor force had left their last jobs due to ill health or disability, less than 15 per cent report an intention to seek another job.
---Studies of older worker job performance tend to disprove the stubborn belief that older people are less effective workers than younger workers; but "there is some truth to the proposition that older workers are more reluctant than younger ones to undertake training for new skills. Frequently this may be the result of a psychological concern that they may fail."

ISSUE: Differences of opinion about the capabilities of older workers continue despite frequently cited studies which

report on positive findings. A new Department of Labor (1979) research strategy paper says that employers still appear to be largely ignorant of recent research findings regarding functional age. Through what strategies can employers be made aware of the capabilities of older workers and given incentives for employing them?

Discussion. The Department of Labor research strategy paper points out the practical significance of the present discrepancy between employer attitudes and older worker capabilities:

> The higher educational attainment levels of today's older workers, combined with accumulating evidence of their retained ability to meet high performance standards, carry clear implications regarding the desirability of training and educating senior members of the labor force. Since learning skills appear to decline insignificantly with age, employers should have no hesitation in opening training and education opportunities (including opportunities for midcareer occupational change) to workers who have reached their middle years. Again, however, employers have not really exploited these possibilities, even though such training efforts might reduce turnover and lead to more advantageous use of available skills.

ISSUE: Does the 1978 law which established age 70 instead of age 65 as the retirement age limit actually reinforce age-ist attitudes? Should a top limit be removed entirely? Should an effort be made in the Congressional deliberations to review current research findings, focus attention on research inadequacies, and suggest means of dealing with these inadequacies?

Discussion. The aforementioned research strategy paper developed by the Department of Labor provides a very comprehensive list of research questions and could well provide the framework for the project suggested above. Another list of issues on very specific current topics was developed by the Committee on Work and Retirement in a Post-Industrial Society at a symposium on White House Conferences as Agents of Social Change in Reston, Virginia, in 1979.

The Committee (Herbert Striner, Chairman; Harold L. Sheppard, organizer) identified the following issues:

ISSUE 1: In view of the growing departure from chronological age as an employment/retirement criterion, what criteria can be developed for measuring performance capacity for use in establishing policy with regard to hiring, promotion, retention, wage and salary rates and retirement of older workers?

ISSUE 2: What procedures can be developed for providing job flexibility through such devices as counseling, vocational retraining, work sharing, part-time employment, tapering off in order to accommodate changing interests and capacities of middle-aged and older workers and to enable employers to continue to benefit from the experience and habits of senior workers?

ISSUE 3: What measures are necessary to bring about the use of CETA funds for (a) retraining older workers and (b) offering opportunities for pre-retirement education?

ISSUE 4: Should employers be granted tax exemptions on funds used to provide/support vocational retraining for older workers?

ISSUE 5: Should legislation be enacted to provide unemployment insurance for older persons who work part- instead of full-time?

ISSUE 6: Should legislation be passed that would permit inter-company and inter-industry pension vesting and portability, cost-free?

ISSUE 7: If private pension systems were to provide cost-of-living pension adjustments, how might increased costs be offset?

ISSUE 8: What mechanisms and logistics would have to be created for raising retirement eligibility ages in order to alleviate the costs of early retirement and to maintain or provide adequate retirement income?

ISSUE 9: What methods might be developed for discrimination and securing acceptance of existing knowledge concerning such matters as (a) the relationship of age to work capacity, as (b) training methods appropriate to learning processes among older persons, and as (c) pension cost/benefits of employing older workers?

ISSUE 10: Are there adequate systems at local levels for reporting occupation-industry needs, training deficiencies, worker performance qualifications and profiles?

ISSUE 11: Will the effectiveness of implementation of the age discrimination in Employment Act change now that its administration is the responsibility of the commission on Equal Employment Opportunity instead of the Department of Labor?

ISSUE: There is a likelihood that current Federal budget constraints will force stabilization of funding for community service work programs or even cutbacks, thus perhaps giving the impression that maximum limits in such programs have been reached. How can the Federally-assisted work programs become the core of a broadened community-based effort within which local organizations define their own needs?

Discussion. The U.S. Department of Labor reported (1980) an enrollment of 48,189 as of June 30, 1979, in the Senior Community Service Employment Program (SCSEP) under which subsidized part-time employment is offered to low-income persons age 55 and above. These persons work 20 to 25 hours a week in a wide variety of community service activities and facilities including day centers, schools, hospitals, senior centers, and rehabilitation and restoration projects. National organizations and state agencies on aging are administrators for individual projects.

ACTION reports (1980) that more than 270,000 persons 60 and over served in its three Older Americans Volunteer Programs (OAV) in F.Y. 1979, including 250,000 Retired Senior Volunteer Programs (participant uncompensated, except for expenses), 3,000 in the Senior Companion Program (SCP) and 16,640 in the Foster Grandparent Program.

The existence of these programs has already resulted in a considerable degree of technical knowledge and information about the usefulness of older persons in service activities in their communities. For example, through the Senior Companions Program, older volunteers directly assist older (and

often institutionalized) older persons to greater self-direction and well-being. The value of one such initiative in New Hampshire was recently described:

> Seven of the 60 SCP project volunteers are former residents of either the New Hampshire State School for the Retarded or the New Hampshire State Psychiatric Hospital. All but one lives in an adult foster home. The clients are from the same age group; many live in congregate housing projects. Physical impairment is their primary limitation. The supervisor of this component . . . recently testified before the Senate Committee on Child and Human Development that as a result of SCP cooperating with other community services, 25 people have been able to avoid institutionalization or have been able to return to the community from an institution. This, in turn, has resulted in an approximate savings of $273,750.00 per year to the community (Hill, 1979).

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A.I.D. #7: National Retirement Policy

CONGRESSIONAL FINDING: "There is a great need to develop a national retirement policy that contributes to the fulfillment, dignity, and satisfaction of retirement years for older individuals."

The goals of a national retirement policy must be set in the context of an accurate assessment of the needs of American Society for workers and the desires of individual Americans for an earned release from the responsibilities of employment. Ideally, a national retirement policy must insure that enough people are employed to generate the needed national resources, and, at the same time, provide retirement options that allow individuals with a sufficient record of service to pursue personal goals in a financially secure context. In this discussion we briefly review the development of retirement policy in the United States, what the current policies are, and what trends can be expected to influence retirement policies in the future. We then identify issues that need to be considered by the White House Conference on Aging.

Background

Historically, retirement meant a withdrawal from mundane matters such as making a living or running a household to devote oneself to more "important" matters such as politics or religion. In the last 100 years or so, however, retirement has come to be seen as a mechanism for dealing with the fact that the processes of aging have physical results for some people that can hamper their effectiveness as workers (Fischer, 1978). For employers, retirement also has come to be identified as a way to phase out expensive older workers and replace them with less expensive ones. For employees, retirement of older workers is often seen as the only way that

opportunities for advancement can be created. For the individual job holder, retirement most often means freedom from the responsibilities of employment. These various meansing of retirement influence how people view retirement and public policies about it.

The idea that aging causes some people to become less effective as workers antedates the development of mandatory retirement, private pensions, or Social Security. Such problems when they occurred were usually handled by shifting failing older workers to honorific positions or to "light duty" jobs. The early 1900's saw the introduction of mandatory retirement policies. This was the result of several factors. Union demands for seniority as the basis for employment security and wages meant that older workers were generally more expensive than younger workers. There was also a general unverified belief that older workers were less effective. Because the average length of life was still relatively short, workers who would be affected by mandatory retirement represented a tiny proportion of the work force. Thus, in return for seniority provisions, unions were willing to accept mandatory retirement (Haber, 1978). Pensions were developed by employers as a means of stabilizing the work force. Without pensions, workers changed jobs much more often. The benefits of many early private pensions could be withheld from the worker for a wide variety of "infractions" (Fischer, 1978).

In the early 20th century mandatory retirement policies were not tied to the provision of retirement pensions. Retirees were often forced into poverty as a result of age discrimination based on beliefs about the effectiveness of older workers and the absence of private pensions. By 1930, the number of retired Americans in poverty had become a serious problem. Social Security was in part a response to this situation.

Social Security retirement benefits were developed according to several general principles. These included:

1. Benefits should be tied to earnings and length of service.
2. Continued employment after age 65 should be discouraged.
3. Social Security should be seen as a supplement to personal retirement resources.

Because many retired people had no personal retirement resources, because Social Security benefits were not adequate to live on, and because age discrimination cut off opportunities for employment, the aged were identified as needing a special category of public welfare. Aid to the Aged, Supplementary Security Income, Medicare, subsidized housing for the elderly and other programs targetted for the elderly have been based on this philosophy.

It is fashionable to state that we do not have a national retirement policy. We do have national policies, however, about when and under what conditions retirement is permissible. We also have national policies about the financing of retirement benefits.

Current Retirement Policies

There are two types of retirement, disability and service. Disability retirement can occur at any age under Social Security and under most employer pension programs. Disability retirement is clearly related to age. More than half of those who apply for disability benefits under Social Security are between ages 50 and 64 (Atchley, 1980:157). In addition, a substantial number of the service retirements that occur before age 62 are probably also related to marginal disabilities--disabilities serious enough to prevent employment in one's customary occupation but

not so serious as to limit employment altogether. Some people prefer to retire early rather than take a lower-paying or less rewarding job. Service retirement is permitted when an individual reaches a minimum retirement age and years of service. For example, under present Social Security regulations, anyone born after 1929 must have worked at least 10 years and have reached age 62 in order to qualify for retirement.

Our national pension policy considers the "normal" retirement age to be 65. This is the age at which people become eligible for full benefits. Our national policy is to permit "early" retirement but to deter it by reducing benefits. Thus, those who retire prior to age 65 receive benefits that are reduced to compensate for the increased number of years the benefits will be drawn. Our national retirement policy contains little incentive for delayed retirement. Benefits do not necessarily increase for those who delay their retirement. In fact, benefits may actually go down for workers whose current jobs do not pay as well as ones they had earlier.

At this time it appears that most people are opting for early retirement at reduced benefits. This trend is due to a combination of factors: job-related disability, availability of private pensions at relatively early ages, employment problems of older workers, workers' desires to devote their lives to other matters, and a lack of other retirement options. Research is needed if we are to know the relative importance of these various factors. We need to know how important these factors are in order to be able to identify needed policy changes should we decide to change this situation in some way.

Our national policy is to finance pensions for retired workers by taxing current workers and their employers. We do this with a tax that

requires the lowest proportional contributions from those workers with high incomes. Our national policy is that Social Security retirement benefits should be both adequate and equitable. That is, average benefits should be adequate to support more than a subsistence life style, and, at the same time, should reflect a "fair" recognition that some people have contributed more to the system than others have. These are somewhat antagonistic goals. In order to provide adequate benefits for people who never earned very much, other people have to get less than they "deserve". The reverse is also true.

In the past 20 years, Social Security benefits have become more adequate. Needed increases in Social Security benefits have been financed both by increasing the tax rate and by raising the amount of earnings to which the tax applies. The price for this has included increased tax pressure on workers and reduced confidence in the soundness of the Social Security system.

Our national policy is that Social Security should provide a <u>modest</u> level of adequate income. Anything more than that must be provided by job-specific pensions or personal resources. In the past, little was done to supervise private pensions. The Employee's Retirement Income Security Act (ERISA) was a legislative attempt to insure that money taken from employees to provide a supplementary retirement pension would have that result. However, public employers and small businesses are exempt from having to conform to this policy.

Our national policy is that retirement should be genuine--that those who retire should genuinely give up job responsibilities and not merely change jobs. This policy is most obvious in the "retirement test". Persons who draw Social Security retirement benefits and are under age 72

are restricted as to how much they can earn and still be allowed to draw their complete benefit. The amount of earnings allowed varies with age. Those who are under 65 (and who thus retired early) are now allowed less annual earnings compared to those who are 65 to 71.

A good bit of the tension about retirement comes from the fact that numerous exceptions are allowed to our national policies. Some employees can draw complete retirement benefits from former employers and still be employed full-time. Others cannot. Some employer pensions are protected by ERISA, some are not. Some employees are covered by Social Security, others are not. These exceptions and others like them are also part of our national retirement policy.

Pressures for Change

In 1978, the Secretary of Health, Education, and Welfare identified four demographic and social trends that are bound to influence retirement policy (U.S. Senate, Special Committee on Aging, 1980):

First:

> Life expectancy has increased almost 10 years since 1940. In 1940, the average life expectancy at birth was about 63½ years, lower than Social Security's retirement age of 65. Today, life expectancy at birth is 69 for men, 77 for women. Three-quarters of the population now reaches age 65; once there, they live on the average for another 16 years, to age 81. As we contemplate the year 2050, we are told that life expectancy will increase only another 3 years for men and 4 for women. And we must remember that biomedical advances have consistently rendered projections of life expectancy too low. [Emphasis added.]

Second: Predicting the transformation of the baby-boom group of this century to the senior-boom of the next, the Secretary said:

> In 1940, roughly 7 percent of the total population was 65 and over; today, the proportion is 11 percent—more than 24 million people. After 2010, the elderly percentage will not just increase: it will soar . . . .

By the year 2030, nearly 1 in 5 Americans--55 million citizens--will be 65 or older. And the composition of the older population is changing also. In 1940, only 30 percent of older citizens were 75 or older; by the year 2000 they will comprise 45 percent of the elderly--more than 14 million people.

Third:

Ironically, while people are living longer, they are retiring earlier. Thirty years ago, nearly one-half of all men 65 and over remained in the work force. Today, among people 65 and over, only 1 man in 5, and 1 woman in 12, are in the work force. There is no indication that this trend to earlier retirement will cease. This confronts us with some serious questions concerning . . . the cost of providing retirement income. [Emphasis added.]

Fourth:

The ratio of active workers to retired citizens will change dramatically over the future: from 6 to 1 today to only 3 to 1 in 2030. This ratio is important because it suggests how many active workers are available to support programs for the elderly. We can estimate this ratio by comparing the number of citizens 65 and over to those 20-64. This is rather crude, since some persons over 65 are not retired, and many people who are 20 to 64 are not workers. But the historical changes in this ratio are extraordinary nonetheless: In 1940, there were 9 citizens age 20 to 64 for every citizen 65 or over; today, it is 6 to 1; by 2030 it will be only 3 to 1.

There are also other trends which will have an influence on retirement policy. The decline in the birth rate will eventually mean fewer young people coming into the job market. This may produce pressures to retain older workers. If the energy crisis intensifies, there may be an increase in jobs as we depend less on automation. Continued inflation may increase the demands for part-time work for retired people.

ISSUE: The major policy issues in retirement policy are:
1. At what age should people be allowed to retire and at what age should they be encouraged to retire?
2. What should the level of retirement income be?
3. How should retirement income be provided?
4. What relationship should exist between retirement and full- or part-time employment?

Discussion. The level of retirement (the proportion of the population retired) appears to be influenced by two factors: (1) the minimum

age of eligibility for Social Security or other retirement benefits, and (2) the financial adequacy of retirement benefits. (See Attachment A) Up to now, opportunities for continued employment have affected the level of retirement only slightly. Thus, as the minimum retirement age goes down and the adequacy of retirement benefits goes up, the level of retirement increases. This is what has been happening in the United States. Recent changes in mandatory retirement policies will probably have little effect on this picture. However, as the needed revenue required to support retired people increases, so do demands for contributions by the working population. For example, the recent rises in Social Security benefits required sharp increases in Social Security taxes over several years. These increased taxes lower the disposable incomes of employed persons. To reduce the tax level, support for other public programs may be lessened. As an example, proposals have been made to partially offset the increased costs of retirement benefits by eliminating Social Security survivor benefits paid to college students.

As the disposable incomes of employed people go down (or at least lose ground to inflation), popular support for adequate benefits for those who are retired also goes down. If this lowered support for retirement benefits causes these to become less adequate, then the level of retirement goes down as people delay retirement in order to boost their expected benefits (Atchley, 1980:290-291).

Policies about retirement age, benefit levels, and partial employment options must accomplish the following objectives:

1. Insure that enough people remain employed.
2. Provide adequate benefits to those who retire.
3. Keep the revenue required to operate the system within tolerable limits.

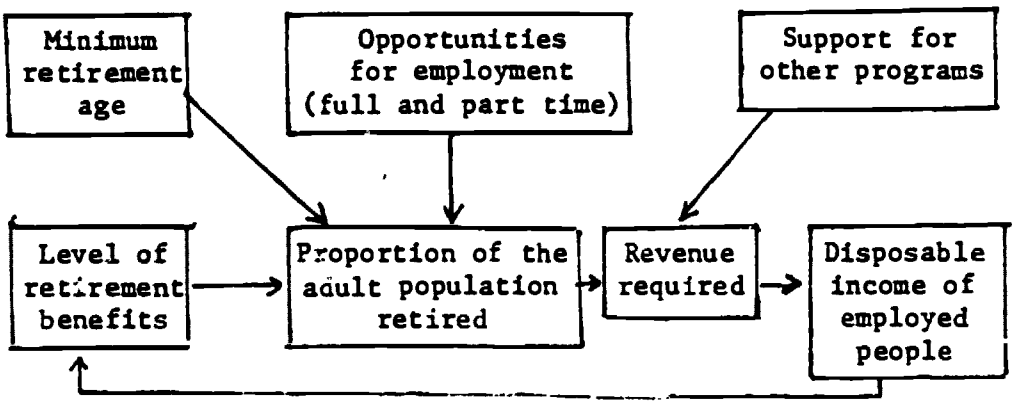
4. Give people a sense that their needs have received sincere consideration.

The number of specific proposals that have been made for changes in retirement policy is staggering, and each proposal must be examined in relation to 1) the factual situation, 2) public opinion, 3) other public policies, and 4) the general objectives cited above. In addition, there is a fundamental issue about the means to be used--about whether incentives or punishments are the more effective motivators. Is early retirement to be punished or later retirement encouraged or both? Is part-time employment of retired people to be punished or rewarded?

It is not realistic to expect the White House Conference to resolve all of the issues involved in this process. What <u>is</u> possible is to develop consensus about the order in which retirement policy objectives ought to receive priority and the implications of these priorities for specific retirement policy issues.

Attachment A

The context of retirement policies can be diagrammed as follows:



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A.I.D. #9: ELIMINATING STEREOTYPES

CONGRESSIONAL FINDING: False stereotypes about aging and the process of aging are prevalent throughout the Nation, and policies should be developed to overcome such stereotypes.

Negative attitudes toward aging and elderly persons have costs going far beyond the emotional toll suffered by those rejected simply because they are old.

Dr. Robert Butler's composite statement of erroneous common beliefs once held (and still stubbornly persisting in one form or another) is a summary of these negative, and false, stereotypes.

> An older person thinks and moves slowly. He does not think as he used to or as creatively. He is bound to himself and to his past and can no longer change or grow. He can learn neither well nor swiftly and, even if he could, he would not wish to. Tied to his personal traditions and growing conservatism, he dislikes innovations and is not disposed to new ideas. Not only can he not move forward, he often moves backward. He enters a second childhood, caught up in increasing egocentricity and demanding more from his environment than he is willing to give it. Sometimes he becomes an intensification of himself, a caricature of a lifelong personality. He becomes irritable and cantankerous, yet shallow and enfeebled. He lives in his past; he is behind the times. He is aimless and wandering of mind, reminiscing and garrulous. Indeed, he is a study in decline, the picture of mental and physical failure. He has lost and cannot replace friends, spouse, job, status, power, influence, income. He is often stricken by diseases which, in turn, restrict his movement, his enjoyment of food, the pleasures of well-being. He has lost his desire and capacity for sex. His body shrinks and so does the flow of blood to his brain. His mind does not utilize oxygen and sugar at the same rate as formerly. Feeble, uninteresting, he awaits his death, a burden of society, to his family, and to himself (Butler, 1975).

Over the past 30 or 40 years Americans have been developing more favorable and realistic attitudes toward older people (Tibbitts, 1979), but further improvement is expected to be slow because: "(1) institutionalized negative concepts and values change slowly; (2) the deteriorations of advanced age and the prospect of final withdrawal will

continue to be negatively held; and (3) further extension of life and growing numbers of aged will increase the prevalence of older adults who manifest circumstances which have given rise to negative stereotyping."

According to Tibbitts, there are two groups of older people:

> "(1) the clear majority who are healthy and as functional as they choose to be, thus to whom negative stereotypes are or will be inapplicable; and (2) those with varying degrees of physical, mental, and/or social disability who display some characteristics that coincide with some elements of negative stereotypes."

Tibbitts adds that "today, increasing numbers of older people, researchers, and practitioners are rejecting devaluation of the majority of those in the second group." This optimistic, if guarded, outlook has been voiced by other leaders and observers in the field. One review of the relationship between public policy and attitudes toward the elderly (Achenbaum, 1978) described the tendency, from the 1920s on, to think of old age as a "national problem." Social Security was a watershed which opened "a new chapter in the history of old age in the U.S. by establishing the first nationwide institutional structure to assist older Americans." The present challenge is described as follows:

> The time is ripe, I think, for discarding the now inappropriate but still prevalent notion that older Americans are problems and for concentrating instead on the problems they have. Furthermore, if we are to reduce the likelihood of becoming victims of our own excessive sentimentality, sensitivity, or cynicism and pawns of institutional priorities or academic predilictions, we must increase our number of experts in gerontology. The Twentieth Century record indicates, in my opinion, that we can and must rely on the insights and resources of both the aging and the aged public.

Neugarten (1979) and others say that the problem of negative stereotypes arises because governmental programs are so often based on age-entitlement rather than needs-entitlement. A means or needs test, is a storm signal for many older persons and their advocacy organizations.

One of the major reasons given for the inclusion of Medicare under the Social Security system in the late 1950's and the early 1960's was the push for entitlement through contribution.

Perhaps the most solid documentation of the damaging effects of age stereotyping appeared in the U.S. Civil Rights Commission Report on Age Discrimination in late 1977. This report found that discrimination on the basis of age in the delivery of Federally supported services and benefits existed to some extent in the following programs, each of which was examined for the survey:

- Community Mental Health Centers
- Comprehensive Employment and Training Act (CETA)
- Vocational Rehabilitation
- Adult Basic Education
- Legal Service Corporation
- Community Health Centers

Under-representation of older persons (and in many cases, teenagers) was consistently found in the Commission study. Program directors are quoted in the report as overtly or tacitly selecting younger persons over older persons on the basis of age-related assumptions, rather than by case-by-case standards of need or suitability.

In response to the recommendations and findings of the Civil Rights Commission, the Department of Health, Education, and Welfare acted to develop regulations for itself and for other appropriate agencies. The difficulties in achieving acceptance of the regulations are described in detail in the U.S. Senate Committee on Aging report, Developments in Aging: 1979, pages 194-197. At the end of 1979, only half of the appropriate

agencies had issued proposed regulations and not one agency had issued final rules.

"However," the Senate Committee reports, "Complaints under the ADA (Age Discrimination Act) are being received and referred to the Federal Mediation and Conciliation Service. The FMCS can take the necessary steps to resolve the complaints between the two parties. If no agreement is reached, the complaints will be referred back to the appropriate agency where some steps can be taken. Although final rulings cannot be made until the agency issues its final regulations, certain courses of action are available to the agency based on its standards and mechanisms for other civil rights statutes."

ISSUE: What strategies can be employed to stop the under-representation of older persons in Federal programs? What strategies are needed to combat negative stereotypes?

Discussion. A review of other A.I.D. papers in this series will reveal direct or indirect reference to situations which are related in one way or another to negative attitudes toward the aged, "ageism," and the costs of ageism. The tendency to associate decrepitude with advancing years has a direct impact on the work force, upon our medical and health care establishments, upon family relationships, and perhaps most directly, upon retirement practices and institutions.

The health care paper, for example, spoke of an institutional bias: a tendency to rely on hospitals, nursing homes, or other facilities instead of finding ways to deal with long-term disability in non-institutional ways. In the mental health area, Eisdorfer (1977) has used the term "therapeutic nihilism" to describe the generally pessimistic attitudes of many practitioners when assessing treatment possibilities for the emotionally-

troubled older person. The very term "senility" has caused untold damage to older patients, to the extent that Besdine (1978) and others describe it as a wastebasket diagnosis. Butler's many complaints about the term "senility" include the observation that 100 other conditions mimic the symptoms commonly associated with senility. Blumenthal (New York Times, 1979) speaks of a state policy in Pennsylvania which makes it extremely difficult to admit a "senile" older person to a state hospital, while at the same time community mental health centers in the same state are enjoined against accepting the same category of patients.

The under-representation of older adults in Federal programs probably stems from many factors: negative stereotypes about older adults, inadequate programs to serve the specific needs of older persons, and negative stereotypes on the part of the older adults about the Federal programs. Research is needed to determine the extent to which each of these factors contributes to underutilization. Once the extent of each factor is determined, then research is needed to determine the means by which the programs can be made more effective in meeting the needs of older persons. For example, if Community Mental Health Centers do not serve older persons, perhaps it is because the techniques they use are not especially beneficial to the emotional problems of older people. What alternative techniques can be employed? How can mental health professionals be trained to employ these techniques? It may well be that effective programs will do much to eliminate negative stereotypes, both on the part of the service providers and the service receivers.

ISSUE: What are the ways in which public policy and widespread prejudice against older people buttress each other?

Discussion. Unemployment problems of middle-aged and older workers become acute in times of economic uncertainty when suggestions are made to the older employee make way for the young. And yet, despite complaints from the U.S. Senate about the practice of inducing older people to take "early retirement" (U.S. Senate Committee on Aging, 1975), this practice continues in the Federal Government and in other public agencies. The counter proposal that the Federal establishment become a model employer in terms of flexible and well-founded practices is still addressed in the future tense, rather than on past accomplishments.

The question of Federal policy impact upon family relations is also one which should be listed among those influenced by stereotyped attitudes toward aging. Policies which encourage institutionalization serve to alienate older people from their families.

Close attention should be given to the Older Americans Act. Criticisms of that program include Estes' firm belief (see A.I.D. #4) that services designed and implemented by professionals in the field cannot be as valid as services designed and directed by older persons themselves, given some essential support from a responsive, but not a directive, government. The decade between 1981 and 1991 could be the period in which such a transfer of direction is achieved or attempted. The success of such an effort would be certain to have impact both upon attitudes toward older persons and their self-conception.

ISSUE: Should the White House Advisory Committee at an early date suggest a cooperative action, perhaps under the sponsorship of the private sector, at which business, labor, and governmental representatives can pose issues and problems related to the treatment of middle-aged and older workers, now and in the future? The participation of the private sector in the White House Conference process has been mentioned from

time to time as highly desirable. What can be done in the near future to assure that this will indeed occur, and that the private sector will be given the opportunity to be an incisive and helpful force in that process, rather than a defensive or skeptical one?

Discussion. Even if government should become a model employer in terms of ingenuity and well-thought-out values related to the older persons in its work force, it is unlikely that the private sector would base its actions upon a governmental model. It is more likely that private and public employees will influence each other and, in a changing demographic situation, will make their own adaptations to a gradually "aging" work force. It is encouraging, then, that the National Council on the Aging, which sponsored a comprehensive survey of attitudes and practices related to aging, finds significant progress in private sector attitudes toward age-related issues.

In support of the conclusion that "a large and growing percentage of chief executives and personnel directors . . . recognize the productive contribution of their older workers," the findings say that industry's leaders now recognize that retirement planning benefits both employer and employee:

"Research," reports NCOA, "tends to confirm that:

- employees who believe that their employer cares about them tend, in turn to care more about the quality of their performance for the employer
- retirees who are satisfied with retirement generally provide positive feedback that improves the employer's image
- pre-retirement programs can improve productivity and morale by enabling employees to make fact-based decisions about when to retire, rather than staying on out of fear of retirement and the unknown
- programs can help employees and their families appreciate the full scope and value of the benefits provided by the employer

- an employer may feel a social responsibility to help loyal employees prepare for a satisfying retirement."

ISSUE: What leadership might the White House Conference take in publicly encouraging changes in the practices of the mass media or of marketers and advertisers that perpetuate stereotypes of older people? Might the conference endorse improved educational programs on aging in the schools, public information campaigns, or other strategies to combat stereotypes?

Discussion. Scientific studies over the last few years have documented the fact that older people are portrayed with negative stereotypes in television dramas (Gerbner, 1979), television commercials (Jamieson and McClain, 1977) and in children's books (Ansello, 1978)——when older characters are present at all.

In a 10-year study of 1365 television programs, Gerbner found that "the over-65s, actually constituting 11 percent of Americans, appear to be hardly more than 2 percent of the TV population." Furthermore,

> "Older people are shown as eccentric, stubborn, nonsexual, ineffectual and often silly. Old men are likely to possess power for evil and accordingly must die, by TV's simple code. Old women have no such powers and usually wind up as victims, especially to the violence that occurs in almost 80 percent of prime-time and childrens programs."

Although it is difficult to scientifically measure the impact of this stereotyping on people's attitudes and behaviors, common sense suggests that the mass media are potent vehicles for crystallizing shared images in a wide audience. Media messages reach not only the "impressionable young", but also employers, service providers and policy makers. A disturbing finding of a 1975 Louis Harris survey was that even older Americans hold negative stereotypes of the elderly in general. Americans of all ages, then, could benefit if presented with images of realistic and positive role models for old age.

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