AGING IN THE USA

ABD'de Yaşlılık

Muammer ÇETİNGÖK

Prof.Dr., Tennesse Üniversitesi Sosyal Hizmet Okulu

ABSTRACT

By the year 2010, in the United States, one out of six (39.4 million) people are projected to be 65 years of age or older, primarily due to the people born post-World War II and increasing longevity, joining the ranks of the aged. In light of this major demographic shift and change of Federal policy position to that of devolution, innovative and effective health and quality of life policies and services for the elderly involving all sectors of the society would have to supplement or replace the ones currently in practice. Social work profession is expected to be even more concerned with the welfare of the elderly. Social work education is responsible to take curricular measures to train social workers for elderly health and quality of life roles within a public-private mix of policy and program packages. Special consideration would need to be given to the challenges of cost-effective health and high quality of life in the design of the curriculum on aging.

Key Words: *Aged*

ÖZET

Amerika Birlesik Devletleri'nde 2010 yılına ulaşıldığında, her altı kişiden birinin, birinci neden olarak İkinci Dünya Savaşı sonrası doğan insanların yaşlılık düzeylerine ulaşmaları, ve ikinci neden olarak, genel yaşama süresinin uzamasıyla, 65 veya daha yukarı yaşta olması saptanmaktadır. Hem bu temel nüfus oynaması hem de Federal Hükümet politikasının "devolusyon"a değişmesi ışığı altında, toplumun tüm sektörlerini içeren, yenilikçi ve etkili, yaşlılık sağlık ve kaliteli yaşam politikası ve hizmetleri, şu anda yürürlükte olanları destekleme ve değiştirme durumunda olacaklardır. Sosyal hizmet mesleğinin, yaşlıların refahı ile ilgilenmesinin daha da artması beklenmektedir. Sosyal hizmet eğitimi, kamu ve özel sektör politika ve program paketleri çerçevesinde yaşlılık sağlığı ve yaşam kalitesine katkıda bulunacak sosyal hizmet uzmanları yetiştirmek üzere müfredatsal (öğretim tasarımlarına yönelik) önlemler almakla sorumludur. Yaşlılık üzerine öğretim tasarımlarının hazırlanmasında, sağlık hizmetlerinin etkili ve yapılan harcamalara değer biçimde olması, ve yaşam kalitesinin de yüksek düzeyde tutulması sorunlarına özel önem verilmesi gerekecektir.

Anahtar Sözcükler: *Yaşlılık*

INTRODUCTION

The elderly (65+ years of age) population of the United States has grown 33.2 million (1 in 8) in 1994. It is projected to be 34.7 million in 2000 (12.3%), and 39.4 million (1 in 6) in

2010. Average annual growth is expected as 1.2 to 2.8%, propelling the elderly population's growth to 78.9 million by 2050 (http://www. census.gov/population/www/dbna/db-aging-toc.html; 9/ 27/ 99 data). Till 2010, the growth is expected to be moderate as the result of the aging of the 1930's Depression Era people, while, beyond 2010, Baby-Boomers are expected to swell the ranks of the elderly at almost an alarming rate (Hobbs and Damon, 1996, 1). Such a growth will take place within the context of increasing longevity combined with the ever-increasing need to subcategorize the elderly population to "young-old (65- 75)"with more than half of the elderly population, "the middle-old (76-84)" with 35%, and "old-old (85 and over)" (which is growing the fastest-Hobbs and Damon, 1996) with the rest of the population (Atchley, 1991). Also, the elderly already are "socially and economically diverse ... and heterogeneous ...(as in) age, race, ethnicity, gender, economic status, longevity, health and social characteristics, and geographic distribution," e.g., urban vs. rural, financially healthy vs. poor, physically healthy vs. poor, retired vs. working, exercising vs. bored, with all "levels, needs, and resources" (Hobbs and Damon, 1996, p.1).

The United States social welfare system is based on the "residual conception", and thus, the business of caring for the elderly is indeed a "patchwork" (McInnis-Dittrich,1994, p.62) of policies and program with both the involvement of public policy makers, government agencies at Federal, State and local levels, and the non-profit, non-governmental (NGOs) agencies. All of the above demographics, characteristics, and qualities of the elderly and resulting implications would need to be taken into account within this public-private policy and service mix. It is also important to acknowledge some of the implications of the specifics of demographic trends. As Cox and Parsons (1994) points out, more people living over 75 will require more health and welfare services; elderly 65-74 years old may need to be reconsidered for employment. Furthermore, subpopulations of female single and widowed elderly, ethnic elderly, educated elderly, economically stable elderly, healthier elderly, and higher ratio of elderly people to working people are all increasing.

PROBLEMS RELATED TO THE ELDERLY POPULATION

Elderly population's problems in the United States could be conceptualized in two different ways. In the first conceptualization, health care, income security, housing (which includes physical safety and security), and social service needs (including recreational needs and management of daily living) are seen as individual and distinct components of the conceptualization in their own rights. Yet, in the second conceptualization, borrowing from the National Institute on Aging, we look at these concerns as forming two major "challenges" to the society for the care of the elderly,and categorize them as: 1) how to produce cost-effective health care?" and 2) how to maintain the quality of life with advancing age (National Institute on Aging as quoted by Hobbs and Damon, 1996, p. 3).

In this conceptualization, while cost effective healdh care is distinguished as the first important challenge in its

own right, income security, housing, and social service needs become the integrated components of the second challenge, i.e., "quality of life." We consider health care as a prerequisite to a life of any quality due to our contention that only after this challenge is given priority, and thus, the road to longevity is clear, then, the quality of traveling the longevity road becomes meaningful with the integrated package of income security, housing, physical safety and security, and social service/recreation being placed on the agenda. We will use this conceptualization while also keeping in mind the cultural orientation of the US society for letting the elderly live an a life of independence -elderly living by themselves in their own homes, in our discussions for the rest of our presentation.

POLICIES AND PROGRAMS FOR THE AGED

The United States, as a society, has been struggling to meet both the cost-effective health care and the quality of life challenges both on public and private responsibility centers within the context of its residual social welfare system. Although the Federal level of government responsibility has been, and still is a major part of the US social welfare system, with the advent of the policy of "devolution," (delegating policy responsibilities to State and local governments (Jansson, 1997), more emphasis is being placed on the knowledge, skills and abilities of the States and local governments as well as the private sector, both in non-profit and profit-making subsectors, to take a more prominent role in the business of welfare in general, and elderly welfare in particular (Jansson, 1997). It looks as if the "values, attitudes, and beliefs"(Cox and Parson, 1994, p.147) of the American society currently indicate a renewed conservatism and the future developmental context for any social welfare policy is to remain as residualism with a heavy State and local government and private sector involvement. Therefore, the role of the Federal Government in the development of unique and innovative policies and programs for the aged could for all practical purposes be seen as one of reluctance and policy uncertainty (Jansson, 1997). The role would mainly be "window dressing" and trying to maintain the "minimal" standards of the so called "welfare state, " while being almost totally confused as to what a welfare state is or should be.

Consequently, the United States, at the Federal level is currently struggling to present an integrated and universal system of care for the aged. On the other hand, States and local governments as well as the private/NGO sector demonstrate some originality in their approaches to policy making and programming with respect to the aged.

The current public policy driven health care and quality of life programs for the aged in the United States are as follows:

With respect to health care for the aged, there are basically two major programs, Medicare and Medicaid, both passed in 1965 as the Titles XVIII and XIX of the Social Security Act. Medicare is a Federal program with policy, financing, and administration vested in the Federal Government. It helps the elderly 65 and over (mostly as a retirement health care

package). It has two parts, Hospital Insurance (HI)-one paying for hospital stays, some skilled nursing home, and home health care services after hospital stays, and the other-Supplemental Medical Insurance (SMI) for outpatient care including physicians' lab and diagnostic services. Payroll taxes, premiums paid by the elderly, and general revenue funds of the Federal government are used in the funding of this program. It is designed as a social insurance coverage and eligibility is an automatic right for all elderly 65 and over who have paid into the system.

Medicare's late history has shown cutbacks and increasing premiums and deductibles, and gaps in coverage such as the lack of long-term nursing home care or home-based health care services. As a coverage for acute health problems and based on the medical model, Medicare has been criticized for not being innovative in terms of responding to the needs of chronically ill elderly with preventive, outreach, and alternative home health care services. It does not cover prescription drugs, catastrophic illnesses, and long term (custodial) care. Furthermore, because of physicians' surcharges permitted over and above government payments to them, it has contributed to soaring medical costs and has forced many chronically ill elderly to the depletion of their personal meager funds, and eventually to being dependent on the Medicaid program.

Medicaid program, which is basically a "public assistance" program for poor elderly, is based on matching grants; Until recently, Federal government extended to the States a substantial amount of funds (50 to 83% of all expenditures varying with the states-poor stating getting more), and set the general guidelines/standards, for Medicaid and expected them to match these funds while at the same time leaving the states relatively free to decide on related policy and management matters. Currently, Federal government approves the state policies and programs as its significant standard setting role with respect to Medicaid, and yet, gives the states complete policy and management control of it as a result of "devolution."

States now have their own Medicaid-related health care policies, i.e., Tenncare for the state of Tennessee, and they have devised what is currently known as "managed care" systems to provide cost-effective medical services to their residents. These programs cover hospital stays, nursing home care, physicians', lab, and diagnostic services. They help the poor elderly, either on the welfare rolls or medically indigent, and require "means testing." Poor elderly, although benefiting from the Medicaid program, are still worried about managed care aspects, and poor quality of care in this program even in its revised form. Medicaid has also been criticized as an expensive, inflationary, non-innovative, and fraud ridden program, costing both the Federal government and the States exorbatant amounts of funds. Current statistics and program evaluations also point to these same problems.

Although the overall health status of the elderly seems to have improved with more access to medical care with the introduction of Medicare and Medicaid programs, the overall health

status of the elderly seems to have improved, costs in both programs are constantly ascending and leaving especially working poor and middle class elderly people unable to pay for health care. Provisions of comprehensive and long-term health coverage and services originating in the 1965 Medicare and Medicaid amendments to the Social Security Act are being reexamined as to how good a policy mix could be achieved between public and private provisions, given the devolutionary stance of the Federal government. The current system for health care for the elderly in the US is, like we stated before, trying to be responsive. Yet, it lacks adequate and cost-effective health coverage for the needs of the elderly. Therefore, although, one could speak of the idea of devolution as something unique and different, its innovativeness could be questioned. Governmental efforts in the United States, both at Federal and State levels at the present time lack a vision as to what a cost-effective health care system should be. As a study indicates, only the elderly in the United States are worried about how to pay for their health care costs as opposed to the elderly of other countries like Canada, Japan, UK, Germany.

With respect to the quality of life components of the elderly care, significant policy developments at the Federal level have been the passages of the Social Security Act of 1935, Older Americans Act of 1965, indexing (i.e., adjusting) of social security benefits to inflation (COLA's-Cost of Living Adjustments), and Supplemental security Income (SSI). Among these Social Security Act, COLAs, and Supplementary Security Income directly speak to income security. Older Americans Act covers other quality of life issues.

Income security is a major concern of the elderly Americans. Social Security income, which officially began with the old age assistance provisions of the Social Security Act of 1935, and which was not intended to be the full source of income, is a social insurance program. It currently appears adequate with enhancements by the indexing program (COLA's) started in 1972. Social Security is currently being considered for a revision as not only a public but also privately managed income maintenance program as in Chile and other countries as the government's role as a guarantor of a steady flow of adequate income is being challenged and reexamined.. Revisions might be in the government transfer of 2% of social security taxes to private market-held stocks and bonds. There is also talk of individual retirement accounts (IRAs). Currently, completely private IRA's, and employer-matched pension funds are already available for those who can afford to have these types of accounts. The debate still continues as to whether this is fair for the elderly and when the stock market volatility and fluctuations may not actually guarantee a steady retirement income. Although, force-field analysis suggests that the forces on the side of securing a governmentally/publicly guaranteed income to the elderly are stronger with the current resources of social security and the viability of the fund have been recently secured by the Federal legislature until the year 2035, questions still linger as to whether or not the fund is safe and secure till then. Lately, however, the repeal of earning

limits for the working elderly who are also on social security retirement income has eased the pressure on these discussions.

Supplemental Security Income, enacted in 1972 as Title XVI of the Social Security Act, is actually a public assistance scheme by which the poor elderly collect some income even if they may be collecting income through for social security, as long as the social security income is less than the SSI income. Lately, there has been a decline in the number of elderly participating in this program due to increased numbers becoming eligible for social security and decline in the poverty rates(DiNitto, 1995, 138).

As a final comment on income security, we can state that social security, SSI, and work opportunities have made the elderly income security within the realm of possibility although the fact still remains that many elderly are strained, and there is a wider inequality between rich and poor elderly (DiNitto, 1995, 335-36).

With respect to housing, there are three major concerns for public and private policy efforts: standards, supply, and subsidies (Dobelstein, 1990, p.177). Current public policy program covering housing is the Public Housing Act of 1974. Section 202 speaks to housing for the elderly. This is a loan program under the subsidy category above for the elderly to construct new or rehabilitate old homes. In terms of supply, well-to-do and retired elderly do not seem to have a shortage of homes since they have already bought their homes and kept them for their retirement. Some poor elderly, however experience fair and affordable housing just like the rest of the poor population. As far as innovative supply strategies are concerned, housing needs of the elderly are being considered to be met in the private homes of the elderly, as well as nursing homes, assisted and independent living, group living, and family care environments, and "gated (Sun City, Arizona)" housing complexes with adequate standards. Most of these are for those elderly able to afford them. Some poor elderly are being subsidized by being housed in the nursing homes or in the Section 8-rental subsidy housing. Supply of public housing which is a direct outcome of construction and/or renovation/restoration, has mostly been in the domain of the private building sector with substantial governmental investment of funds.

As regards the social services, the major legislative action is the Older Americans Act of 1965. In addition to including objectives of health, income security, and housing, this act also speaks to housing, restorative services, employment, recreational activities, transportation and other community services for people 60 or older. This Act has put in place a network of services at all governmental levels, with the Administration on Aging (AoA) at the Federal level. At the state level, either free-standing or health-department related agencies on aging try to implement the requirements of the OAA. And, at the local level, Area Agencies on Aging (AAA's)-600 of them-distribute funds to community agencies for nutrition, senior centers, information .referral, homemaker, home repairs, home health assistance, shopping. visits/telephone calls, escorting, transportation, and legal services. Lately, efforts have

been focused on the strengthening of services to cut the use of nursing home and other institutional stays by the elderly. There is also a growing interest in the provision of guardianship services to manage the assets of the elderly-although with some civil rights problems of its own. All of these services mentioned above are in transition. Furthermore, the needs of the poor and special care elderly are testing the abilities of both public and private agencies.

On the private/NPO side, more Non-Governmental Organizations (NGOs) are being attracted into both health and quality of life service areas with some financial input from government organizations (Dolgoff, et al., policy book, and DiNitto,1995,p.55). This attraction is due the efforts of the US presidents Reagan and Bush during whose time of office, privatization became a major theme for social welfare. Privatization fills the gap and thus serves as the reflection of "residualism" and the lack of Federal universal coverage of elderly health and quality of life services in the United States. In a capitalistic society such as the US, this is seen as a social opportunity for the private sector to respond rather than an unfortunate act of omission by the government.

Thus, the United States is witnessing an expansion of privately (profit/ non-profit) owned and operated health care (health maintenance organizations-HMOs, Preferred Provider Organizations-PPOs, and Managed Care Organizations-MCOs (Dinitto, 1995), and quality of life service agencies for the elderly. Health care has always been an attractive area for private/profit making sector, and social service areas of elderly day care and addiction treatment have always displayed private service schemes. Furthermore, supply of public housing has been mostly in the hands of the private/profit making sector. Now, many more private (profit, nonprofit) agencies are moving into the field of health and quality of life care for the elderly. It is assumed that at least 200 thousand nonprofit agencies serve the needs of the elderly based on the projections of Corman's (1987) statistics to date. These nonprofits are primarily expected to meet the needs of not only well-to-do but also limited income and poor elderly.The number of profit making agencies is also on the rise for reasons of public conservative attitudes towards social welfare, efficiency of private businesses, and venture capitalism into new and uncharted businesses. Profit making sector is expected to primarily meet the needs of those elderly whose incomes are adequate to afford the profit making modus operandi (motives) of this sector (an example would be a recent development of housing units in Memphis, TN with costs of $3,000 per month).

In summary, current public policies and programs, well intentioned as they are, are not adequate to meet the health and quality of life needs of the elderly. There is no integration among them nor do the programs based on these policies have consistent internal strength and adequacy to meet these needs. There are questions of fairness, and equality with respect to the distribution of policy and program resources. Policies have been formulated and programs developed within, and accommodated, many years of residualism. Safety net

for the elderly years is defective with still even some subsistance and maintenance needs for health care and quality of living areas of income security, housing, and social services being unmet.

Current private sector(both nonprofit and profit) policies and programs have been trying to accommodate and yet are ineffective in closing the gaps created by the inadequacies of public policy. With the proliferation and renewed determination of private organizations such as Senior Services agencies (nonprofit and catering to all needs) and Marriot Corporation (profit and primarily catering to the housing need) establishing themselves in the field of aging based on the supportive federal policy movement of devolution and corresponding societal 21st century conservatism, we expect these organizations to stay around and contribute more to elderly welfare. We expect the private sector to be in partnership with the public sector and segments of this sector to be designated as the developers of policies and providers of services on a rotational basis. Such a partnership would necessitate public funding of private agencies in direct proportion to the cost sharing by these private agencies. Overall, policy and programmatic issues of who benefits? (universal vs selective provision), what benefits are provided? (cash, in-kind), financing/funding, and management of policy provisions and services along with specific focus on availability, accessibility, and adequacy would need to be defined within the context of an public/private integrated system of policy making and provision of services.

FUTURE CURRICULAR CHANGES REQUIRED FOR SOCIAL WORK EDUCATION

As we move into the 21st century, we expect to see the schools of social work in the US to be even more concerned with the needs of the elderly. Considering the severity of these needs and problems besetting the elderly as highlighted by the White House Conference on Aging held in 1995, the schools of social work cannot afford to ignore their educational and training roles for the benefit of the elderly population.

The schools are also realistic enough to realize that the societal "values, attitudes, and beliefs" are in favor of devolution, and in continued favor of residualism, not of universalism. This presents a challenge for the schools of social work to design curricula for a public-private mix of provisions of care in all areas of help to the elderly. Time has come for the schools of social work to take a stand for the creation of fair and just universal systems for health care (Beverly and McSweeney, 1987) and quality of living for the elderly, and yet achieving this in the context of a public-private mix.This means teaching of policy practice (formulation, analysis, and advocacy) as well as program management applied at the Federal, state, and local governmental levels while at the same time providing content on the characteristics and role of the private sector in policy making and service provision and management.

Although we acknowledge the existence of some programs educating and training for services to the elderly such as U. of Southern California's Andrus Gerontology Center, we pro-

pose the following guidelines be used for curricular development in the field of aging both in the US and internationally, by the schools of social work.

1) The "two challenges" conceptualization, cost-effective health, and high quality of life, mentioned above, would form the basis for curriculum development; Health care would be taught as one major package, and quality of life concerns taught as another, and as an integrated package.

2) These two challenges would be addressed at the macro level with policy practice and program approaches to macro change (Netting, Kettner, McMurty, 1998, p. 300).

3) The concept of "devolution" would need to be accommodated into the macro level change.

4) The role of the private nonprofit/profit sector in the macro level policy making and provision of services to the elderly would need to be acknowledged and their integration into the macro level policy making and programming accomplished.

5) The concepts of "empowerment" and "advocacy" would need to permeate the curriculum to prepare and enable the elderly to influence the directions of policies and programs at the public(federal and state and local) and private(profit/nonprofit) levels and procure what they need for better health and quality of life.

The five guides for the design of curriculum above lead us to state that every school would need to have a curriculum of course work and field practice in aging with the following major components: An advanced policy practice course, a course on legislative process at all governmental levels (implications of the concept of devolution would need to be better understood especially at the state and local levels), an advanced field practice, an advanced public aging policy and programs course, an advanced course on the characteristics of elderly, a course on advocacy and empowerment with also a content on diversity, social and economic justice, a course on the elderly programs and services by the private (nonprofit/profit making sector), a course on privatization, a course of the management of private organizations (non-profit and profit making), and a course on the research with aging, the principles of public-private sector partnership in developing policies and programs.

In summary, schools of social work in the United States are at the crossroads of making major curricular decisions. Although some have traditionally offered programs, most are either awakening to the need, or re-tooling to include courses related to the multidimensional care of the elderly in responding to an National Institute of Aging estimate of 65,000 social workers needed by 2020 (Cox & Parsons, p.11). With the Baby Boomers generation (75 million born between 1946 and 1964) to become of retirement age by 2010 and swell the ranks of the aged, as well as the general population getting older as a result of living longer, the education issue becomes even more urgent. It has become almost imperative that social work schools be at the forefront of efforts to teach and train social workers for redesigning of income security, health, housing, and social welfare policies and services for the elderly.

In this context, a redesigned curriculum for the elderly would have to be given serious consideration as suggested by Cox and Parsons (1994).

PROMOTION OF INTERNATIONAL COOPERATION AND COLLABORATION

We propose that one way for international cooperation and collaboration is to adopt and implement the above curricular design and share the findings based on experiences globally. Having had the benefit of studying the policies and programs with respect to elderly at least in our three countries, we are of the opinion that, the conceptualization we are advancing in this presentation for design of elderly curriculum does fit to the concerns of the elderly. Schools of social work would have to be the global agents of change when it comes to reconceptualization of education and training for services to the elderly. Also, international cooperation could further take place as social work educators, contributing to the integration of public and private policy making and programming efforts through national teaching and consultation roles, could share their experiences and research findings internationally.

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