SOCIAL SERVICES for the ELDERLY

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THE FREE PRESS
A Division of Macmillan, Inc.
NEW YORK

Collier Macmillan Publishers
LONDON

To Mary Elizabeth Cashel and Nancy Sutter,
who encouraged and assisted me through the several
years of writing this book

The Free Press
A Division of Macmillan, Inc.
866 Third Avenue, New York, N.Y. 10022

Collier Macmillan Canada, Inc.

Printed in the United States of America

printing number

2 3 4 5 6 7 8 9 10

Library of Congress Cataloging in Publication Data

Huttman, Elizabeth D.
Social services for the elderly.

Includes bibliographical references and index.
1. Aged—Services for—United States. I. Title.
HV1461.H88 1985 362.6'0973 85-1593
ISBN 0-02-915600-9

Preface

The purpose of this book is to inform readers about the many types of services that can be of help to the elderly. Above all, it is to make readers aware of alternatives to the nursing home. This book should be of use to the practitioner, the student of gerontology, and the potential client or caretaker of a client.

Many persons have helped in the preparation of *Social Services for the Elderly*. Great appreciation goes to my Free Press editor, Laura Wolff, who provided useful suggestions and had enormous patience. I thank Edith Lewis of The Free Press for her work in producing the book. I thank Nancy Sutter for her help in typing the manuscript, as well as several typists in Zermatt who provided ready assistance in a time of need: Katja Bergman, Vreni Lembo, and Heidi Stadlman. I would like to thank the following people for useful advice: Kathleen Charmez, Anna Dickerson, Isabel Haigh, Elinore Lurie, Joan Nixon, Elizabeth Ratiu, and Phil and Lil Sturgeon. Ulrich Inderbinen, the Furrer family of Chez Beny, Brigadoi Myrta, and Cathy of François provided a pleasant atmosphere in which to write. Last, this book would not have been possible without the patience and help of my husband, Dr. John Huttman.

Contents

CHAPTER 1

Introduction: The Aged and Their Needs

Purpose of the Book

This book provides a detailed description of services that cover the basic needs of the aged. It highlights creative alternative programs and discusses current policy debates on appropriate types of service provision. Since these services or programs are often multidisciplinary, I draw on knowledge from many different fields. The information here should be valuable for health personnel, physical therapists, social workers, and students engaged in a wide range of jobs for agencies working with the elderly. Such agencies may call upon the services of sociologists, recreation workers, architects, lawyers, economists, and biologists, to name a few of the variety of disciplines involved.

The purpose of each chapter is to describe the service in question at some length. Equally important is the critical examination of both shortcomings and successes of these services. This will help students to develop new programs or reshape existing ones when they become practitioners. Likewise, students serving as caretakers for aged relatives can choose an appropriate support program to supplement the informal support provided by the family. Many research studies of services for the elderly have been used for my critical evaluation, including my own research on housing services for the aged in the United States, Canada, Great Britain, Holland, and Denmark.

Another goal of this book is to make students aware of the existing alternatives to institutionalization. Those unfamiliar with this field are often inclined to direct the frail elderly person with a health disability to a nursing home. The average person is unaware of the wide variety of community-based services that have been developed in the last decade—services which can prolong the aged person's stay in the community or can preclude use of the nursing home entirely.

We clearly need a continuum of care: different services directed to the aged in different degrees of health. The aged have a variety of needs; if they are to be met, services must be tailored to the individual's particular circumstances.

Outline of the Book

The first chapter examines the social and psychological characteristics of the American aged population. In this chapter I present a service model which serves as a conceptual tool for reading the rest of the book. In the second chapter the focus is initially on present issues at the national level concerning overall policymaking and planning for services to the aged, including the debate on Medicare reform. I then shift to a discussion of priority setting and coordination of activities planning at the local and state levels under the Older Americans Act (OAA). The next chapter deals with "linkage"—groups and programs set up to facilitate use of the service system, such as information and referral centers and case management services. The chapter concludes with an examination of the need to protect older people from abuse, and of the means available to achieve that goal. Chapter 5 provides a description of the natural support system for the aged, i.e., the family and the neighborhood network. Subsequent chapters are devoted to different programs and services within the formal support system. This entails detailed exploration, in chapters 6 and 7, of telephone contact services, friendly visiting, volunteer and paid work, senior citizen center programs, and meals and transportation services. Chapters 8 and 9 describe housing programs, first those in the aged's own home and then those in specially designed housing. Chapter 10 focuses on adult day care, while Chapter 11 treats long-term services for the chronically ill, from community home care to nursing homes. The last chapter covers income maintenance programs, with special attention to reform of the Social Security program.

Definition of Gerontology

It is important to define gerontology clearly at the outset. It is a fairly new field which started mainly as the scientific study of the aging process. When founded in 1945 the Gerontological Society of America centered its interests

on such biological aspects of aging as physical changes in the organism which accompany advancing age: changes in cell structure, internal organs, and bone structure, as well as other changes in the body's general functioning. However, researchers trained in the social sciences became increasingly active in the field, developing theories on such matters as age stratification, role change, and disengagement. Writings inspired by the social gerontology viewpoint gradually gained recognition; in 1974 the Gerontological Society finally established a research project in social gerontology.

Social gerontology can be described as the scientific study of the social and psychological aspects of aging, i.e., adjustment to the later stage in the life cycle. It is concerned with group behavior and with the emotional–affectional aspects of development that occur as individuals advance through the last part of life.

For several decades gerontologists have been concerned with the implications of social gerontology for the manner in which we care for the oldest part of our population. Practitioners have used the social gerontologists' findings on adjustment to aging to help plan their programs for the elderly. From the first White House Conference on Aging in 1961 through the 1981 conference, both academics and practitioners have worked closely to make recommendations that would improve the well-being of the elderly.

Roles of the Gerontology Specialist

Human services experts work with individuals, groups, and the community. This work takes many forms. The worker may be directing a program for the elderly or using his special skills in such fields as social work, recreation, or medicine for a particular program in an agency. He works in a variety of settings: from a nonprofit social service organization to a community recreation program; from a special housing development for the aged to a community health clinic or hospital; from a mental health clinic to a federal agency such as the Social Security office; from a homemaker program or adult day care center to a nursing home or a company's retirement counseling office. The worker may provide direct service, such as counseling, to the elderly person. This counseling may be of an informational and referral nature or it may be individual, in-depth casework.

Another job of the human service worker is to inform older people of the services available. She may need to take the client to the service, help fill out forms, and otherwise act as guide through the bureaucracy. Since many of the aged have multiple needs, the worker may have to contact a number of agencies and counsel the family on different courses of action. She must be knowledgeable not only about the character of the programs, but also about their accessibility to the person involved and that person's ability to meet the programs' eligibility requirements.

The human service worker may try to encourage funding sources—private nonprofit organizations, local, state, or federal legislative bodies—to underwrite new programs. The worker may help plan the development of innovative programs such as adult day care centers. Groups like the Gray Panthers are also frequent advocates of new programs.

But the human service worker's main job may be to link services to each other; the worker acts as coordinator and broker in the field, trying to remedy gaps in services and overlapping.

Characteristics of the Elderly Population

A Diversified Group

Numbering over 26 million, the aged are as varied as the rest of the population in their life-styles, economic situations, religions, and their ethnic and social statuses. As for health, even those of the same chronological age are a diverse group: physiological changes are occurring, but deterioration does not affect all elderly at the same age in the same way.

In fact, the term "elderly" covers such a broad span of life, from age 65 to 90 or 100 or more, that one can hardly assume all elderly will experience the same physiological changes. We may classify persons 65 and over as aged, based on the social security pension definition. According to other definitions, age 60 (or even age 55) counts as "old." Clearly, we need to break this diverse grouping into subgroups. Some experts now divide the elderly into the young-old (65 to 75) and old-old (age 75 and over), or into the healthy aged and the frail aged. We can also divide them into single (usually female) households and husband–wife households. In spite of all these variations, however, we may generalize that for this entire aged population good health becomes less probable (especially after age 75), energy level decreases, and mobility declines. In addition, this group has lessened chances for employment and faces loss of income status.

At this point in the life cycle individuals also suffer increasingly from loss of kin and friends. The small urban family, often separated geographically from its aged members, and perhaps approaching retirement itself, is frequently unable to provide more than token support. The social service system must supplement what families of this sort can do. Before providing details on this family support system, however, let us examine some historical changes in the situation of the elderly.

The Historical Situation

The presence of a large population aged 65 and over is a relatively new phenomenon. It is only in the postwar period that this category of people has

been widely singled out as a special group called "senior citizens" or "older Americans," although the demographic category of "65 and over" dates back to the Social Security Act of 1935. For most of our history the large majority of citizens died before 65 or, at the most, shortly after reaching that age. Average life expectancy in the seventeenth to nineteenth centuries was short; a retirement period as such was unlikely to occur. Life in the frontier farm communities, the mines, or the industrial towns was hard; working hours were long, and living conditions were primitive for many. Survival itself was difficult. Women often died in childbirth, infants at birth or shortly thereafter. The general population was exposed to killing epidemic diseases.

There were, of course, always some who reached 80, 90, or even 100 years, but their number was few. In 1900 the average life expectancy for children born in the United States was 47.3 years. The elderly—those 65 and over—represented only 4 percent of the population (Soldo, 1980).

The Present Demographic Picture

By the 1980s there had been startling changes. There were about 26 million Americans aged 65 and over in 1981; one out of nine Americans was classified "elderly" (Brotman, 1982). Many "young elderly" under 75 had living parents and were members of four-generation families. The average life expectancy at birth in 1983 had reached 74.5 years, with it longer for women than men (U.S. Census, 1983). This meant that many of those reaching age 65 were likely to live on for another decade or more. For example, at age 65 the average man could expect to live for 14 or 15 more years, and the average woman for 18 or 19 more years. Modern medicine had eradicated many killing diseases; doctors had developed successful surgery and other treatments to keep vital organs functioning; pharmaceutical firms had developed "miracle drugs." Many people with serious illnesses were benefiting from these medical advances; they had high recovery rates and often lived on into their 70s or 80s, even after major surgery.

This latter group, those 75 and over—often referred to as the old-old—has thus become a larger part of the population than ever before. In 1950 less than 33 percent of all elderly were in the old-old group of 75 and over; by 1980, 38 percent were. Moreover this group increased more than the "young-old": from 1970 to 1980 it increased 48 percent, compared to a 27 percent increase on the part of the entire 65-and-over population (Soldo, 1980). The predictions for the next decade and a half (to the year 2000) are that the number of people who are 85 years old and over will increase 65 percent; those 75 and over are projected to gain in number by 53 percent. By the year 2000 almost half of the elderly will be 75 and over, and the elderly as a whole will constitute a sizeably larger proportion (one in eight) of our total population (Neugarten, 1977).

Since those 75 and over make up the population group most in need of medical or social services, its rapid growth means increased demand for these services. For example, if only 5 percent of the elderly need home care, this amounted to over 1.3 million people in 1983.

SEX

An additional reason that services will be needed is because such a large population of the old-old population consists of women living alone during widowhood. Because of the longer life expectancy of women, there is a significant gender imbalance in the older population: there are 67.6 males for every 100 females age 65 and over; by age 85 there are only about 43 men for every 100 women. Over 40 percent of women 65 and over live alone. This is because half of the women in this age group are widowed, another 4 percent are divorced, and 6 percent have never married. Males are far less likely to be widowed (about 13 percent) or to live alone (14 percent) (Soldo, 1980).

Of course, not all widowed women live alone; approximately one-fifth of them lives with relatives or someone else (Glick, 1979). Women in the age group 85 and over are the ones most likely to live with relatives because of health problems and because of reduced income. This *dependent* living arrangement is often not to their liking. Approximately 4 to 5 percent are residents of such institutions as nursing homes or mental hospitals.

LOCATION OF ELDERLY POPULATION

Geographically, the elderly are overrepresented in the inner cities because so many of them established homes there before the mass exodus to the suburbs occurred. However, some of the younger elderly were part of this out-migration which started in 1947; in the future, as suburbanites age, there will be a larger elderly population in this part of the landscape. This prospect is a troublesome one, for the low density of the suburban population makes it harder to develop programs for this group of the aged.

In rural areas, where—as in the cities—there is a sizeable aged population, the inadequacy of services has long been evident. People there must travel long distances to reach senior centers or health facilities. The new migration of retirees to rural areas may increase the call for, and eventual provision of, needed services, but distance will remain a problem: in such places the informal network of family and neighbors must play a larger role than elsewhere.

In general, the elderly who have living children tend to live near one or more of them (Shanas, 1980). They usually live near the place where they have resided most of their lives. While some middle-class elderly have moved to the Sunbelt, they represent only a small proportion of the total

elderly; among the noninstitutionalized elderly, only 18 percent of those 65 to 74, and 16 percent of those 75 and over, have changed places of residence during the years 1975–79 (U.S. Census, 1983). When they do move, most of them remain within the same county. However, the small proportion that does move to Sunbelt areas substantially increases the elderly population there; for example, 18 percent of Florida's population in 1979 was elderly, while in St. Petersburg, it was nearly 30 percent (Soldo, 1980).

LABOR FORCE PARTICIPATION

Less than a fifth of all men 65 and over were employed in 1981. Half of those 60 to 64 were holding full-time, year-round jobs (U.S. Census, 1983). Some elderly do part-time work, but as a rule, retirement is total rather than gradual or partial. And it is starting earlier: In 1981, half of the male retirees had taken social security retirement before age 65; that is, they had retired with the reduced benefits provided for those in the age bracket 62–64. According to a Louis Harris poll (1975) most of these were voluntary retirements: the study found that only 14 percent were nonvoluntary. These were due mainly to ill health, disability or mandatory retirement policies. Some retirees are "discouraged workers" who, having been laid off during recession periods, discover that age discrimination, although illegal, works against their returning to the labor force.

INCOME

For many, early retirement is due to greater affluence, based on a substantial company or government service pension, social security benefits, assets acquired because of higher wages, and increased value of real estate (73 percent of the elderly own their own homes) (Soldo, 1980). It should be kept in mind that such assets are different from the income assets described below because they are nonliquid. The greatest financial asset for most, the house, is not a liquid asset. Since most elderly do not want to sell their homes, or even to mortgage or refinance them, this asset does not provide them with disposable income.

Income figures are the usual measure by which to judge the elderly population's financial situation. In 1981 the group's median income, while only slightly more than 50 percent that of younger American families, was high enough to keep most of its members above the poverty level. It was $12,965 for male-headed family households. Overall, 14 percent of the noninstitutionalized elderly were living below the poverty level. For elderly singles the situation was worse. For unrelated elderly individuals, the median income was $5746 for men and $4957 for women in 1981: this was very close to the poverty level. Twenty-five percent of unrelated males and almost 33 percent of unrelated females were defined as living in poverty,

whereas only 8.2 percent of elderly family householders were in poverty (U.S. Census, 1983).

Since the poverty level of the aged is so low, especially for single elderly ($4,901 in 1982), many experts include the "near poor," that is, those with incomes 125 percent of the poverty level, in the general group of elderly poor. Adding this "near poor" group greatly enlarges the size of the elderly poor population. For example, in 1981 almost 30 percent of elderly couples' income was less than 125 percent of the poverty level, which was set at $6,875 for a couple (Rivlin, 1983). This meant that at least a quarter of the elderly were living in poverty or near-poverty. This does not count the "hidden poor" who live with adult children or other relatives.

The older elderly are more likely to be living in poverty because their assets and their pension benefits have been eroded by inflation or have decreased because of the number of years in retirement. The most hard-pressed group is that of older single women, 75 and over (Hess, 1980). These women try to maintain a house or apartment on less than $5,000 a year. Often they resort to stopping or curtailing their use of electricity and gas and to cutting down on food purchases. They sleep late in winter in order to conserve fuel; they eat less in order to cut food costs (Douglass, 1982).

Another economically deprived group is the black and other minority elderly. In 1981 there were 2 million black elderly, over one-third of whom lived below the poverty level (U.S. Census, 1983). The most needy group is that of the old-old black female group; approximately two-fifths of them live below the poverty level. The Hispanic and the Native American elderly population are also in a very bad economic position. Because these groups are underrepresented in the aged population because of lower life expectancy, and because they usually live in rural areas, on reservations, or with relatives, their plight has largely been ignored. Due to these factors and because of discrimination and language barriers, they make little use of the various services available, such as senior centers and nursing homes. But as their life expectancy and numbers increase, and the various services and workers become more accessible, they may partake of services more readily. Many groups, such as the Black Caucus, have advocacy organizations working to improve the situation (Jackson and Walls, 1978).

HEALTH STATUS

As life expectancy statistics indicate, the older population stays healthy longer today. The aged now suffer mainly from chronic, rather than acute, health problems: the leading examples are arthritis, hypertension, and heart disease (each affecting 20 percent or more of the aged), as well as diabetes. In fact, only 14 percent of the elderly surveyed in 1976 claimed that they did not have a chronic health problem (U.S. Department of Health and Human Services, 1980).

Not all of these chronic problems seriously limit the activities of the elderly. In a self-report study of noninstitutionalized elderly (65 and over), only about 18 percent said that they could not carry on major activities; 9 percent reported that by their definition they were in poor health. About 5 percent were housebound; only 1 percent reported being bedridden. As one would expect, members of the older age group (75 and over) in this study—some 23 percent—were more likely to be unable to pursue their usual major activities (Huttman, 1977).

The elderly are also more likely to be hospitalized—one out of six in 1979. In that year they occupied at least 30 percent of all U.S. hospital beds, and they endured longer stays than the average middle-aged patient. The aged in 1979 received a quarter of all drug prescriptions, although they comprised only 11 percent of the population. The noninstitutionalized elderly had an average of 6.3 visits to a physician each year (Soldo, 1980).

Biophysiological changes in the body cause these illnesses. Because the aging period takes up such a long time, it is hard to define the process of changes with the desirable precision. Biophysiological changes come at different ages for different people. Some develop degenerative problems in their 60s, others in their 80s. Even within the same person's body, changes occur at different times in different parts of the system (Rockstein and Sussman, 1979).

Decline in physical capacities is one aspect of biophysiological aging. Loss of energy is common, although preventitive measures, such as regular exercise, can minimize the loss. Physical energy may be reduced because of the system's lessened capacity to deliver oxygen and nutrients throughout the body and even to remove waste products. Most usually function less well as one ages. Changes in the bones and muscles generally cause a number of problems (Glass, 1977). Diminished bone and muscle mass, along with changes in the joints, cause an increased number of falls and fractures. Conditions such as arthritis (degenerative changes in the joints) cause stiffness that can effect psychomotor performance, limit mobility, and slow reaction time. Cardiovascular impairments may affect physical coordination and the ability to walk or to respond quickly.

Impaired hearing may be due to changes in structural and metabolic factors in the inner ear (Rockstein and Sussman, 1979). Communication becomes difficult; even if the speaker shouts to the hearing-impaired person, it may be heard as a booming of unintelligible sounds. Vision also changes as one grows older. The eye has trouble focusing on close objects, so that reading becomes difficult. The older person is more likely to develop cataracts.

Chronic conditions like heart disease, strokes, and cancer take a toll on many parts of the body. These illnesses also involve heavy emotional strain, and decrease the energy level. Chronic high blood pressure, along with the medication used to treat it, can cause dizziness (Finch and Hayflick, 1977).

In general, the nervous system, especially the brain, changes as part of the aging process. However, some problems that laymen often associate with the normal aging process, such as dulling of memory and/or learning disability, are not typical, but due to some prior incapacity or to debilitating change. The most common organic brain disorders fit this category, including senile dementia–Alzheimer's disease and arteriosclerotic psychosis; distinctions among these are hard to make (Kart, Metress, and Metress, 1978). The core manifestations are memory dysfunction, dislocation or disorientation, impairment of cognitive ability, such as comprehension and other intellectual functions, and emotional instability, such as depression and moodiness.

In concluding this section on physical impairments, let us remember that *most* elderly have more than one impairment, especially after the age of 75 or 80. On the other hand, these impairments, even if multiple, usually impose only mild limitations: most of the aged are able to cope with them. The burden can be eased, however, if services are available which make it easier for the person to function in an independent way.

Psychosocial Aspects of Aging

Aging takes on psychological dimensions for the elderly (Bengston, 1973). Individuals react differently to the changes that occur in later life; these reactions can, in turn, affect general functioning and social relations. Furthermore, physical health can be affected by the psychological and social problems associated with aging (Birren and Schaie, 1977).

Role Loss

A major social and psychological change that the elderly experience in this stage of life is role loss and role change. Here the term "role" means filling a certain recognized position, such as that of a mother or a lawyer. Most of the aged are given very limited roles in our society. With advancing age, they are forced to drop earlier roles; they gain few new ones. In their sixties, men and women usually move into job retirement and suffer role loss; in addition, women experience severe attenuation of the mothering role.

These losses are hard to take. In our society people are taught to carry on the roles of paid occupation (for men, and increasingly, for women), marriage, and parenthood. These institutionalized roles shape and direct identity and social status. Many people invest most of their time and energy in these roles. Women, for example, may devote their lives to caring for their children. Men—and increasingly women as well—invest themselves heavily in careers; either of the sexes may carry on the role of family "bread-