1989

Aging Society: Conflict and Struggle Toward the Establishment of the Meaningful Life for All Generations

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AGING SOCIETY:
CONFLICT AND STRUGGLE TOWARD THE ESTABLISHMENT OF THE MEANINGFUL LIFE FOR ALL GENERATIONS

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AN ABSTRACT PRESENTED TO THE FACULTY OF THE GRADUATE SCHOOL OF LINDENWOOD COLLEGE IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF ARTS IN GERONTOLOGY

1989

Abstract

Winter of our life--

A smell of leaves is fallen.
The chill finds its way in the dry wind.
Leaves little room for a coy disguise.
Reflection of our life,
Underneath the crammed seams,
Is vivid and no-lies.
Only a blind man, sitting on the corner,
Busy smoothing his gray beard,
Can recall his dreams.
A song of geese is beaten on the ground.
When the ice engraves our wrinkles,
Our memories are flatten
And worn out.

Statistically, the past few decades showed the rising living standards of the elderly. Social Security benefits have increased almost 50 percent in real terms. The traditional stereotype of the elderly as sedentary, decrepit and poor seems no longer correct. We picture the rosy life of many elderly with substantial assets and discretionary income, despite the fact that close to 43 percent of them live below 200 percent of the poverty line of $10,000 per year.

Advancement of medical technologies brought increasing health costs and a greater burden in income support of the elderly. Longer life expectancy and nursing home expense caused budget

crises in Medicare. Looking at the future, cuts in Medicare and Social Security will bring about more burden on the part of the supporting generation and the elderly themselves. If the current situation continues, baby boomers will not be able to expect a stable retirement life as a majority of today's retirees enjoy.

Elimination of anxieties about growing old is the necessary duty of the society. Public and governmental assistance should contribute to the welfare of the whole community. There is a need for coordinated strategies on the heterogeneity of the older population. The chronological age no longer must not be used as an appropriate measurement to allocate federal budget and community support. Our last stage of life should be viewed as a highly variable stage, reflecting the distinctive needs, interests and physical abilities of particular individuals.

A lifelong process of interaction between the individual and the larger society, pursuit of any life style and, at the end, health maintenance have to be established to foster an understanding of the life of mankind. Society must provide the means and environment in which optimal health may flourish.

The complexity of clinical manifestations, mental confusion and the multiple pathologies of aging should be learned by all generations through health education.

The overall welfare of the generations, the proper function of medicine, and a fitting understanding of the aging process and death should be equally emphasized to any stage of our life course. The degree of satisfaction of each individual is what composes the satisfaction of the whole society.

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THE GRADUATE SCHOOL OF LINDENWOOD COLLEGE IN PARTIAL
FULFILLMENT OF THE
REQUIREMENTS FOR THE DEGREE OF
MASTER OF ARTS IN GERONTOLOGY
1989

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Chapter I

INTRODUCTION

The demographic transition in the last half of this century has remarkably changed the life of the elderly. The number of individuals age 65 or older has already doubled since 1950. An increase in the absolute number of needy persons, due to the increase in the elderly population, called for the expansion of Social Security and financial protection for the elderly. Today, as we race from an industrial to a service- and information-based economy, industrialized nations are being forced to invent the future. In particular, there is no model for how to deal with such radically new social and demographic conditions as the rise of the "Silver Wave" of aging. This paper discusses current issues of an aging society and different proposals for future changes to bring meaning to growing old and, as a result, to enhance roles of all generations in society.

In many aspects, American Society believes in the importance of independence and individualism. Morality of independence is tied to work ethics and

to productivity and also to social and economic independence. The dependence between generations rarely is happily prolonged. In this cultural context, people who have greater independence are evaluated as having higher morale and more self-esteem than those who have less independence. As we abandon the ties between generations and pick up new cultural norms with more emphasis on individualism, the most reliable and protective support of the family diminishes and the risk of isolation and insecurity increases (Cowgill, 1986).

The political decision to shift the primary burden of health care and Social Security for old parents from their children and families to government was one of the great and still unfolding consequences of the end of the great depression. It relieved children and families from financial obligations toward their parents and was intended to increase their affectional sphere. However, it has turned out to be a financial and emotional burden of the elderly themselves and of those who support them. The coming of the silver wave is certain to bring about changes in every aspect of life--from finance and business to art, music and politics. To

design a strategy for dealing with the elderly in the 21st century and to avoid making foolish social and political policy decisions, we need to rethink the widely accepted idea that the older members of this group are no longer productive members of society.

The pain of being old in an industrialized society is that people are valued by the scale of productivity. Mandatory retirement pushed the elderly out of work and their group, in general, was defined as a less productive homogeneous species. The wave of changing society and the roles of older adults came with modernization. As a result, the traditional functions older people performed in pre-industrial societies were taken away.

Growing old in modern society should not only mean living leisurely, nor should it be a natural and necessary preparation for withdrawal from one's society and for eventual death. Traditionally, people aged, but with the convincing satisfaction of having lived through many of the changes of their community. By living where they were, the old continued working and added the responsibilities of a grandparent. They advised and encouraged the young people in their community and gained positions

of leadership in the organizations that held society together. This removed some of the pressure from those in middle age and provided control that gave the older generation its prestige, power and indispensable identity. They brought the wisdom of experience, when their knowledge was needed to deal with a crisis or emergency, and they kept themselves posted with the news young people bring. When this two-way transmission ceases, both the young and the elderly suffer.

An interview of American elderly parents shows that exchanging help with adult children is still a common and enduring experience for older Americans. Older parents' and their adult children's perceptions of their relationship reflect both members' developmental stake in a relationship which reflects both generations' needs for autonomy and interdependence. Several researchers have noted that children living closest to parents, especially daughters, and those expressing high levels of attachment and filial obligation, helped the elderly most frequently (Thomas, 1988).

However, some family support involves burdens on the children's part depending on the frequency and levels of support they have to provide. Also

older parents' reaction to receiving help from adult children indicates that they worry about burdening their children. With each advance in medical technology, doctors and ethicists wrestle over how long one should be kept alive and how to ration health care between the young and the very old. Closer to home, many "sandwich families" (household headed by adult children who support their children and old parents) will feel a terrible strain as they try to raise their children and sustain their parents on a squeezed household budget. Furthermore, it may also be the case that prolonged life expectancy will lead to a greater need for general health service. Financial pressures on the elderly themselves, and especially their families, increased when longterm institutional care is required. The economic pressure on younger generations and government decision on longterm care support is likely to yield more tension in the near future (Gibbs, 1988).

Chapter II

POLITICAL ISSUES

Current Welfare System and Demographic Transition

Over the past 30 years the elderly's standard of living has improved faster than that of younger generation. The economic situation of the elderly population has improved dramatically over the past 16 years. Since 1970, Social Security benefits have increased 46 percent in real terms whereas inflation adjusted wages for the rest of the population have declined by seven percent. Median adjusted family income for families headed by people 65 or older has risen to $22,000 a year, which is more than a 50 percent increase, whereas young families with heads under age 25 saw their median income fall by 15 percent. The elderly's poverty level is now lower than that of the non-elderly. In the real world, the traditional stereotype of the elderly as sedentary, decrepit, and poor is no longer correct.

The greatest social benefit now enjoyed by the elderly comes from a Social Security system that

provides a minimal level of financial maintenance and heavily subsidized health care. In Western society, there has been a gradual enlargement of the social unit deemed responsible for the economic support of dependent and destitute persons. Initially, society relied on family support, but when family resources were not available or were inadequate, individuals in need resorted to begging alms from voluntary providers with their goodwill. Then when the needy began to overwhelm the resources of local religious parishes, the state began to take a hand, requiring local parishes to take care of their own, but only their own residents. The alms began to resemble taxes and public relief system.

During the time of modernization and world depression in 1930s, the relief financed and systematized by the government were applied to the principle of social insurance and welfare service. Most countries have some kind of governmentally administered program under which people in desperate need, including old people, may be given assistance. Though there have been plenty of relief programs mainly considering people's economic needs, few find it adequate and beneficial to take up the issue of

the elderly as one separate division for this purpose. In other words, when the primary issue was moderation of hunger, most societies did not bother or could not afford to classify the recipients by age. The revolutionary change in age structure which has taken place quite recently and very rapidly, hit the majority of Western nations unprepared institutionally and culturally. It is not an exaggeration that this state should be temporary in nature.

Looking at the future, it is time to emphasize that there is tremendous income variation within the elderly group. For example, there are still a third of the elderly blacks, many widows and other really needy, including the oldest old who live on less than $5,300 a year. The oldest old and black elderly compose the fastest growing and the poorest portion of the elderly population. In 1980, almost 40 percent of aged blacks, and overall fully 20 percent of age 65 or older lived in poverty and there is no sign of that statistic declining.

Prolongation of lives increased the poverty level, especially of old women, in the industrialized nations. In Japan, the extent to

which older women live alone is much greater than for men. In 1980, 11.2 percent of all women aged 65 and older, as opposed to 4.3 percent of all men aged 65 and older lived alone. Including the proportions in hospitals or institutions, 15.1 percent of older women lived without kin support and in a relatively poor financial situation (Callahan, 1986). In the United States at every age women were more than twice as likely to live alone in 1980 than in 1950, and more likely to share a house with a nonspouse relative or with an unrelated person. By 1980 even the oldest of the elderly women were more likely to live alone than were the elderly women in any age group in 1950 (Holden, 1988).

The traditional protection programs and benefits which apply to individuals 65 or older simply because they reached 65, might not be appropriate any longer. Henry Fairlie said that one argument against basing financial assistance programs on age alone is that, given two people of the same age, it is most likely that the poorer of the two will be in worse physical condition, unless an extreme version of survival of the fittest holds. Recently, a view of the elderly by the general

public is that they are relatively well off, politically powerful, and eating up too much of the federal budget. This new view has led to considerable debate about whether or not the problems of senior adults have been emphasized to the neglect of the problems of children, thus pitting one generation against another and raising the question of whether programs should be based on age or on need (Fairlie, 1988).

Importantly, it is not only a question of government, but as Carroll Estes has said, of "The aging establishment. . . the congeries of programs, organizations, bureaucracies, . . . providers, industries, and professionals that serve the old in one capacity or another." Even if an organization like the Nation Council of Senior Citizens concentrates on assisting the needy and helpless, it is trapped into supporting the fat in the entitlement programs that goes to those who are not necessarily the deserving poor. As previously noted, many elderly have substantial assets and discretionary income, but that overall financial pictures of older American is less rosy than the mature market analysts would have us believe. As a

matter of fact, close to 43 percent of elderly persons live below 200 percent of the poverty line of $10,000 per year, creating a negative image of the aged (Estes, 1988).

Society tends to overlook these complexities of the elderly population. Some old, for example, encouraged by federal programs and powerful lobby groups seclude themselves in places where they associate only with other aged people. It is a real retirement from society. An extreme example of this attitude is given by Henry Fairlie:

> ---The Complete State Guide to Retiring in the South and West of the United States . . . . Some of them (retirement community) are for the rich. LaJolla, just north of San Diego, has a population of 30,000 . . . it also has 400 doctors . . . where the middle-aged are terrified of the possible cost of medical care of their families . . . nurses told me that the medical care for many elderly patients was really cosmetic, to disguise the natural process of aging . . . . yet it is not the rich communities that are most alarming. The vast industry of "Sunbelt Retirement" is not built on the rich. It is built on federal programs for the elderly. (And of course even those doctors in LaJolla are sustained largely by Medicare.) . . . . Senator Daniel Patrick Moynihan has dryly observed that the United States may be "the first society in history in which a person is more likely to be poor if younger rather than old . . . . They live with reflection of themselves. They are set apart, no longer of a piece with any larger society, with no obligations. Everything is provided. For the first time in their lives, in effect, they have servants. . ." (News Republic: 1988:20).

From a practical perspective, it is much easier to administer a program on the basis of age because there is less room for interpretation than there is about need. There may also be resistance on the part of recipients to declare themselves needy, whereas they might more willingly admit to their seniority. Furthermore, from a political perspective, an elderly constituency may be more powerful and better organized than a poor constituency. As an observer of the American political scene has noted, "It does not take much political savvy to realize that an entitlement program based on need runs a much greater risk of being killed or inadequately funded than does one that distributes benefits to all classes (Martin, 1988)."

Medicare in 1965 and other health care systems did not really foresee problems to come within two decades. In the 1970s great progress was made in improving services for elderly persons. Now it is hard to see why people age 68 should enjoy a lower tax burden than those 65 or younger with the same income. R. J. Samuelson says that most Social Security income is tax exempt. The elderly also

have an extra standard deduction. These two tax breaks cost about $15 billion. Excluding so much spending for Social Security and federal retirement programs (about $250 billion) from budget cutbacks means bigger cuts or tax increases for the non-elderly. A temporary freeze or cutback in the cost-of-living adjustment (COLA) would produce savings without devastating the industrial beneficiaries. Moreover, retirees should not be fully protected against inflation anymore when workers are not keeping up. In 1940 the average person worked until age 69. Poverty for retirees was often crushing. In the mid-1950s Social Security was so skimpy that wages and salaries had to be the elderly's major source of income.

Future Prospects of Intergenerational Conflict

The problem is now reversed. In 1986 there were five working Americans younger than 65 to pay one for older person's Social Security benefit. As the baby boomers age and the demographic center

moves upward, the allocation of resources becomes more difficult and the possible conflict between generations becomes greater. In a recent survey, 69 percent of respondents age 18 to 45 described themselves as not very confident or not at all confident about Social Security's future stability. It is certain that there will be Social Security when they retire. But Social Security will not be as beneficial for future retirees as it has been for their parents and grandparents. And in the next few decades the realities of a rapidly growing roster of beneficiaries supported by a shrinking base of workers will force Congress to vote for changes that will make the system even less lucrative. The question is, only if we set aside the important issue of whether it is appropriate to keep up with current programs, how much will society pay to have the Social Security system (March 21, 1988).

According to Lee Smith, the Congressional Research Service estimates that workers who earned the maximum income covered by Social Security taxes and who retired at age 65 in 1987 will recover their combined employer and employee payroll taxes, plus interest, within about 12 years. But a 33-year-old

employee who earns the maximum covered amount and retires in the year 2020 will wait 31.3 years to recover his or her combined employer and employee contributions plus interest. By 2030 the baby boomers will reach 65, and the ratio of non-working population will increase. The retirement age should be reconsidered to give us an opportunity to work longer and to keep the ratio decrease as low as possible, as our health and life expectancy have improved (1988).

It is said that Congress has already mandated that the age for normal Social Security benefits be gradually raised from 65 to 67 between 2000 and 2027 for those who were born after 1959. To help Social Security deal with financial convulsions brought on by the aging of the boomer generation, the normal retirement age may be lifted even higher (Samuelson, March 21, 1988). Schiffers adds that younger workers today may have to wait until age 68 or later to collect full retirement benefits. It will still be possible to retire as early as 62, but the age 62 benefit will gradually decline to 70 percent of the full pension from the current 80 percent (1988).

A wealthier old population is properly being

asked to do more. For example, Medicare recipients would pay the added costs of catastrophic coverage for major doctor and hospital bills, but not for longterm care under a plan now being considered by Congress. It will also happen that median income people--$25,000 for single, $32,000 for couple--pay more income taxes on Social Security benefits. Currently, they pay federal income tax on up to half of their Social Security benefits. A relatively small proportion of the elderly are affected by this provision. But unlike benefits, these threshold amounts are not indexed to take the effects of inflation into account. Further taxation of benefits will also most likely happen (Samuelson, March 18, 1988).

The Congressional Budget Office estimated that the final budget proposal of the Reagan administration will produce a deficit of $120 billion which is far above the target of the Gramm-Rudman deficit-reduction law. As Bush is taking on revising the budget proposal, health issues including longterm care insurance for disabled and elderly will be stymied (St. Louis Post Dispatch, February 2, 1989:50). Samuelson says that it is

likely that our public discourse suffers from myths. Social Security is still seen as a pension, with payments coming from contributions (though today's worker's payroll taxes support today's retirees, not current workers' future retirement).

George Bush is proposing cuts in Medicare and Social Security, which will be taxable to all income level recipients, if his proposal passes. Social Security will not be increased regardless of the future increase of cost of living which will save $8.9 billion. Though the idea of changing COLA was said to be breaking a contract with retirees, COLA's increase rate will be reduced for the next five years at two-thirds of the inflation rate. Medicare will be cut largely by freezing payments to hospitals at the inflation rate for one year ($3 billion), raising Medicare supplemental-insurance premiums to cover 30 percent of costs ($2.1 billion), and increasing Medicare deductible for supplemental physicians' services to $200 ($1.5 billion) (March 18, 1988).

Congress reported that the trust funds into which Social Security taxes are paid started to hold surpluses. In 1987 the surplus was $20 billion: by

1993 it is planned to be $97 billion. The idea is that these surpluses can be drawn down when today's baby boomers retire (Smith, 1988). Schiffers contends that for now, Social Security seems flush with cash, thanks to the 1983 rescue package that trimmed benefits slightly, provided for their partial taxation and sharply accelerated increases in the payroll tax. The key to the success of this program is the accumulation of a huge current surplus from which the boomers will eventually draw.

In 1988 alone, the combined Old-age And Survivors Insurance and Disability Insurance (OASDI) trust funds was estimated to collect $32 billion more in taxes than it paid out for benefits and administrative costs. With the earning of interest on the money in the trust funds, around the year 2030 the OASDI funds are expected to peak at about $21 trillion, then start to decline rapidly until the money is exhausted in 2048 (1988).

There are, however, a number of difficulties to be traversed before the longterm health care can be assured. So far the efforts to abandon the pay-as-you-go approach of Social Security taxes have ended up creating nothing but confusion and bad policies.

First of all, the Social Security Administration's (SSA) current estimate of the longterm fertility rate after 2021 is inconsistent with the longterm downward trend. The situation will be more tense when a realistic estimated rate of 1.6 births per woman is taken into consideration, though SSA assumes a 1.9 rate. Also, health care costs will force Medicare into the red within the next 12 years or so. Although Medicare is technically separate from the old-age pension program, the fortunes of the two are inextricably linked. The 7.51 percent payroll tax on wages, levied on both employers and employees, is allocated between OASDI (6.06%) and the hospital insurance segment of Medicare (1.45%). When the pension trust fund faced a shortfall in 1983, it was permitted to borrow from the hospital insurance fund (Smith, 1988).

The most devastating fact, however, is that the trust funds into which Social Security taxes are paid and their surpluses, are invested in Treasury securities that cover deficit spending elsewhere in the budget. When Social Security spending will need to be raised in the 21st century, the remaining working-age Americans would have to repay these

loans for the government. It could also lower Social Security spending.

In 2015 America may decide that today's baby boomers should work longer or receive less, though they are paying for current retirees benefits. Also, recent improvements in the supply of services caused a greater demand or higher expectation of service provision and it will be more so as years go by. The issue here is how we overcome the mismatch between our desire for government benefits and our willingness to be taxed. It is crucial, in the long run, whether government benefits are equally distributed based on the degree of need and whether taxation is overburdening the workers.

In 1988, 30 percent of the annual budget went to expenditures on people over the age of 65. Federal expenditures for Medicare, for example, have been projected to rise from $74 billion in 1985 to $120 billion in 1989. A need to cut down benefits and to redesign health care for the elderly seems cruel when recent achievements in retirement benefits and health care are enjoyed by today's elderly. However, if the current form of programs and benefits is maintained another 40 years, almost

two-thirds of the budget will go to supporting the old. According to R. J. Samuelson, by 2010 the over 80 population will double to 12 million (March 21, 1988).

Medicare covers almost no nursing home expenses. Medicaid may not pay for nursing homes unless families are virtually destitute. By the time baby boomers retire, all the most destitute may have to pay income taxes on their Social Security checks. And the tax on their benefits may be greater than they can humanly imagine.

Although any longterm program would cost billions, most of the presidential candidates have committed themselves to doing something. Maybe they were intimidated by the two million members of the American Association of Retired Persons (AARP). More likely, they sense that the unknown burdens of chronic illness frighten most Americans. The difficulties of caring for the elderly show three unique features. The price of an extended life span is an increase in chronic illness and it is less curable than controllable. The quite large proportion of the oldest of the elderly is in poor health, and it makes it painful to care for the

elderly who are dying, incompetent and almost incapacitated.

New medical technologies and health care programs that have developed so rapidly in the last decades were originally established for the betterment of our life in general. New technologies are constantly improved to treat older patients and as a result, Medicare has been extended to cover those advanced medical treatments. In 1986 patients in their sixties had successful liver transplant operations that were considered too risky for people in the age bracket in 1980. With an aging population, there will be a larger waiting list to use those technologies through their own wishes which will eventually increase hospital and doctor bills. Health costs will be a greater problem than income support.

In 1988, an aging population and technological improvements have spurred orthopedic operations, sales of implants and profits for hospitals. Sales of artificial knees and hips in the United States alone should reach $925 million this year, up from $549 million in 1986. Knee implant operations would increase at an annual rate of 15 to 20 percent and

hip procedures would increase at an annual rate of eight to ten percent at least through 1990. A significant factor has been a sharp reduction in hospitalization for implant surgery. The average hospital stay for a knee implant dropped to 12.1 days in 1987 from 18.8 in 1982. Such reductions are crucial for hospitals when they are being paid under Medicare.

Federal Medicare guidelines create reimbursements for 470 illness categories called Diagnosis Related Groups (DRG). If the cost falls below the guideline for an ailment, the hospital keeps the surplus. If the cost exceeds the federal figure, the hospital absorbs the loss. The agency administering Medicare has lagged in making adjustments for improvements in implant surgery (St. Louis Post Dispatch, February 5, 1989). Thus, the guidelines' average limit for a Medicare knee or hip replacement still reflects older techniques and longer hospital stays. As the aging of our population, advancement of medical technologies and improvements in retirement benefits have occurred simultaneously in such a short time, we all were left unprepared. Thus, it seems like we only can

wish for the best out of this difficult situation with little historical evidence of its consequence or its remedies.

We might imagine a great reformation in current programs which no one clearly comprehends. Or, we simply might fight with them for a few decades. However, even if we can find the way out without much effort, why do we care for the elderly and what is it within us that makes us allocate quite large expenditures on health care for the elderly? And finally is it right, while the majority of us insist that age alone does not steal our vitality and independence, that we argue that reaching official retirement age alone entitles us to special treatment?

The goal of gerontology and any field related to aging should not be to extend the upper limit of human life nor retirement benefits, but to make the elderly less burdensome physically and more rewarded emotionally. There are many policies and supports passed into law or being refined every year. They will be introduced to us as support to the elderly and families who are needy, but this may not be a realistic point of view. Any society in any history

has never failed to provide for needs of powerful and wealthy groups, but many failed to do so for the needs of truly needy persons.

Before we, baby boomers and the financial contributors to current retirees' benefits, criticize the wealthy and powerful elderly of today; however, we must examine closely that when it is our turn, we will be healthier and probably more politically powerful than today's elderly and will make aggressive demands. The real issue largely lies in the conflicts between generations that pursue their own advantage and happiness. So far overall societal alternatives and efforts to solve these issues simply shared unintegrated various viewpoints and consequently intergenerational struggle arose. It seems that governmental and public concern with the subject will continue to increase in the years ahead. It is a hope that we all would agree that an important future target for us is to avoid institutionalization and provide motivations and the means, where necessary, for the elderly to remain independent and productive and for families and government to support those elderly who cannot support themselves. The continuous

challenges on the aging issues will bring a social progress to us all. And the negative social norms and cultural assumptions of the aged group should be replaced with major revisions and a positive promise to all generations.

Chapter III

SOCIAL ISSUES

Age Roles In Society

In all societies traditionally and presently, people have defined the various stages of life differently. These age expectations may fit for some people in some societies, however, they often lead us to misconceptions. Each individual differs to a great extent within the same age group. Besides this age grading system which is institutionalized generally by legal regulations, there exists as well a system of age role expectations that define definite relationships between the behavior or role-performers and specific ages.

The disengagement of the elderly from positions of social responsibility to the orderly operation of society has started with an attempt to explain how and why society defined the elderly in different ways from younger people. At the same time, rapid social change in the industrial societies encouraged the continuous replacement of older workers as a

function to keep the skills and training of workers as up-to-date as possible. These expectations are no less obligatory than legal regulations. Although, they are transmitted only by tradition and not by law, they still specify social norms for members of different age groups. Of course, this age-status system is influenced not only by cultural change, but also by social prestige, sex and economic factors. Accordingly, differences exist within the age ranges to which certain role expectations are assigned. Some expectations are attached to very limited age ranges, and some to wider ranges. Role expectations toward the aged can be separated between generalized and personalized assumptions of old age (Macionis, 1987).

The inconsistency between societal expectations toward the members of an age group and their real behavior increases as the aging population increases. In industrial societies, where younger people are the mainstream of economic development, the influence of the elderly decreases. A very critical stage in the development of this discrepancy is a mandatory retirement system and the elderly workers' wish to remain socially active. In

a rapidly changing society, older people tend to be defined as marginal or even obsolete. They are thought to be unaware of new trends and fashions, and their wisdom is often seen as irrelevant to the changing social world of younger people.

Although many studies demonstrate the efficiency of many members of this age group in their jobs, the unemployment records of different industrialized societies point to a fairly high degree of discrimination towards older workers. Retirement may fit the common image of being a period of recapturing one's life after years of contributing to the society, but it often produces a sense of detachment from familiar routines, if not outright boredom. This discrimination can be seen as an outcome of the negative stereotype of the aged which exists in society and which irradiates from old age into middle age. This irradiation is one of the results of a mechanism which was characterized by Rosow in 1962 in the following way, "But now it should be clear that the crucial people in the aging problem are not the old, but the younger age groups who determine the status and the position of the older persons in the social order" (World Health

Organization, 1983).

The study of the generalized stereotype of the aged shows that in the modernized society the image of the aged is defined as a decline and loss of functions and capacities. Socialization within old age differs in an important way from socialization during the earlier stages of life. For the young, advancing age typically means entering new roles and taking on new responsibilities. Old age, however, involves the opposite process--leaving roles that have long provided them with their social identities and a source of meaningful activities. The aged are perceived as unhealthy, inactive, malfunctioning, and inefficient in their thinking; they are oblivious, obsolete, stubborn, isolated, nonproductive, and eaters of the government budget; and they are seen as asexual or if even showing sexual interests, as ridiculous. The perception of the aged is also related to health, retirement and institutionalization. Old age, beginning in the mid-60s, is the final years of adulthood and of life itself. Societies attach different meanings to this last stage.

T.A. Lambo, the deputy director of the World

Health Organization (WHO), describes conditions for the older generation's in developing countries as high in public opinion. Few problems as a group are so well known, compared with the elderly group in the West. Of course, there are individual problems. But the group is better adapted to society than in the more advanced countries. He also pointed out that conditions and symptoms of this maladaptation appear to be much more mild in their manifestations in the Third World than in the industrialized countries. Dr. Lambo attributed this to what he calls a "Cultural Buffer", based on the highly developed family and neighborhood responsibility for the whole community--young and old--as well as to a high social tolerance for behavioral deviations (1983).

This poses a number of questions. Can the developing world learn from the developed countries? If so, what can be learned about science, biology, medicine, delivery of services, and economy? Secondly, can we in the industrialized countries learn from them? If we approve of their system, can we take steps to go back, only if appropriate, and again place more responsibility on the elderly

within their community and society? Can this step be encouraged by educational, financial and other means, or have we gone too far, and is the trap closed behind us? Finally, if the developing nations in varying degrees face the problems of industrialization, urbanization and other social and cultural problems, will they have the confidence to keep the values and roles of the aged?

The norms developed from stereotyping of the aged are contradictory to very well known needs and desires of the community aged. Whereas these persons perceive themselves as active in social engagement and activity, social norms ask for the opposite behavior. The original idea of this disengagement theory was that this process benefits the elderly themselves. As one's physical capacities diminish, they presumably welcome relinquishing some of the pressures of performing occupational tasks. Retirement is one clear example. But the current retirement system at age 65 will simply increase the proportion of the nonworking population.

In the years to come, ever-greater demands will be placed on social resources and programs that

provide support for adults aged 65 or older. Also, like any transition in life, retirement demands that a person learn to participate in society in new and different ways while simultaneously unlearning patterns and routines of earlier stages in life. As most older people of this generation have been socialized to adapt to the social norms existing in this society, they will become less active, less sociable and less engaged than they would wish to be. It should not be overlooked that the transition requires the nonworking wife or husband to change routines to accommodate a spouse now spending more time in the home. Some psychologists say that our interpretations of human behavior color our assumptions about the various stages of life and assert that some dimensions of intelligence may even increase as one ages.

The problem of incorrect public assumption is even more central to continued activity and social participation in old age than are all the medical and psychological findings on conditions for better physical and mental health and for longevity. Furthermore, aged persons with a more negative self-concept have a more negative attitude toward younger

people. Apparently these aged persons try to compensate for their low self-esteem by having low esteem for some scapegoat group. It also demonstrates the difficult situation of the aged who perceive themselves competent in a society which perceives them as incompetent. It is probably agreeable that negative characteristics of the aged group prevail just like they do in any age group; however, there are also positive aspects of this stereotype. According to one's own self-concept as developed in childhood and adolescence and stabilized during adulthood, the aging persons will perceive the different aspects of this stereotype in a selective way. An aged person with a more positive self-concept will perceive only the more positive aspects of the generalized stereotype of the aged, and an aged person with a more negative self-concept will choose those aspects in agreement with his own self-concept.

It is likely that this youth orientation will diminish as the proportion of old adults steadily increases. The percentage of Americans over 65 has risen almost threefold since the beginning of this century. Today there are more Americans in old age

than in their teens. Moreover, as the average life expectancy increases, more and more Americans will live well past the retirement age. The last few years have witnessed a dramatic and, for the most part, welcome new accent on the positive aspects of aging. Developmental psychologists have begun to view old age as a period of continued growth and development--with a sense of integrity, accomplishment, and personal wholeness. A perception of old age as a period of unique capacity for wisdom, for understanding the experience of a whole lifetime and for service to the young are evidenced to help offset the negative psychological effects of inevitable physical decline. These positive aspects, however, should not be misinterpreted as a richer view of aging, but rather as a fundamental dimension of human existence. The elderly market as business' new target group can contribute to a meaningful old age by providing those goods and services that foster autonomy and contribute to a sense of competence without setting the elderly population apart in the process. Also more importantly, the effort of advertisement and promotion targeted to an elderly population will

play a key role in improving both society's perceptions of elderly people and older people's images of themselves. However, this leads societies to distorted images of the actual financial condition of the most elderly, redirecting attention away from the still sizeable proportion of elderly who live in poverty or near poverty. The invention of the "old market" can play an important role to meet the health and social needs of the elderly population, and yet sometimes cause the serious dilemmas posed by the extensive targeting of the new gray market in a heavily consumerist nation.

Looking to the next century, the United States Bureau of the Census (1984) predicts that the fastest growing segment of our population will be those over the age of 85. It is projected that there will be almost seven times as many people over that age a century from now as there are today. Importantly, old age will become a much more common part of everyone's daily experience. The 21st century will bring young people into far more direct contact with elderly people in their family and community. It will be necessary for younger people to understand the process of aging and the

responsibilities of caring for the aging for both generations' sake.

Social Policy and Preparation for Retirement

There is a need for a balanced approach to all generations and support for policies which will enable the elderly to have the dignity of independence and respect. Policy makings tend to be based on negative incentives which suppress the generations instead of offering positive incentives to support the family in aiding older members. Policy has not always been based on biological, psychological, sociological and gerontological knowledge. The family should not only be a function of demographics alone, but also of cultural, geographical and historical situations. Social policy, addressing all the problems of the aging within the family on the need to assess the functional capacity of older persons, and to develop policies in such areas, should be based on their capacities and not necessarily on chronological age.

In the future, there must be a development of

social policy for the family with needy, aged, handicapped, etc., which does not overlook the increasing number of the aged without family. Middle age adults are under pressure to take care of children as well as the aged. The change of family formation, related to a number of social changes, has resulted in the high divorce rates, the emergence of the four-generation family, older parents-older children-adult grandchildren relationships, and older persons without family support. There are thus changing expectations of support between generations. It was suggested that society should respond not by replacing the family with bureaucratic structures, but rather by supporting the family's functions and other supplemental support systems in the care of older persons. For example, strengthening home-oriented services such as home health care or peer group networks to increase the independence of the older persons themselves must be established. In the context of the loss of family roles, widows compose the largest part of older people, especially of the very old. Here we can observe a generation of widows not socialized for an active mastery of an urban environment, and not able to seek, find and

take advantage of services that are available. This phenomenon was especially noted in widows of low educational levels. In these cases local social networks, such as neighborhood networks, can be seen as a resource to be exploited in assisting older widows to use those resources that have been made available in modern Europe and Northern America (Rowles & Ohta, 1983).

Often, in policy debates, there has been too much reference to the aged in terms of burden or dependency as if they are a burden on the entire community or as if they depend too much on other groups in the population. Decisionmakers need to note the importance of sifting out the generalities that are perhaps possible from the nationally specific findings. One important theme is the need for differentiation in our perceptions of the aged. The practice of treating them as masses of people rather than as individuals stands in the way of improved policy--they do not compose a homogeneous age sector. Especially the current social welfare system that defines the needy simply by statistical research and handles the mass of old beneficiaries, should be reformed to identify and support only the

real needy in an individualized way. For example, myths about poverty levels and medical needs between poor and non-poor must be cleared up to prevent illness from further damage and to provide early cures of chronic diseases. The old must be distinguished from the very old and the frail from the independently functioning and well older person. We need to be reminded regularly that the institutionalized elderly form only a very small percentage of the older population. We should not emphasize the problems and the dependency of the aged too strongly because it distorts the actual situations of the older population. There is a need for some rethinking in this connection towards a more appropriate description of need among many old people such as being gainfully employed.

Nancy Gibbs and Meredith Minlker discuss that the prior policy question is the unemployment or underemployment of the aged. Full employment involving the government should be considered. There were 62.2 percent of people aged 55-64 still in the labor force in 1968. In the late 1980s, however, there are only 54 percent of this age group in the labor force. There is a need for a

nationwide effort to solve the problems of aging because these issues can no longer be dealt with alone. Finally, we are of the view that for all practical purposes the elderly, especially the retired elderly, can still be employed in a variety of activities. Many of those over 65 who prepared themselves for a life of satisfaction find they are not cut out for it. For them satisfactory life still means to be fully active in society. Sufficient attention should be given to how they can be gainfully employed even after their mandatory retirement within the context of the community. Some local and national organizations of the elderly have already started their own programs to encourage the elderly to become productive again and remain an organic part of their society. Old people are knowledgeable about the basic programs in their society, the ignorance of any cultural heritage and the rotten manners. The shadow work of millions of volunteers in schools, hospital wards, prisons and arts centers has helped fill the opening left by women volunteers who are now career women. Many elderly see such volunteer service as a duty as well as a joyous experience. With flexible schedules,

part-time work, creative business organization and a shorter work week, millions who are now thrown aside could contribute to society and retain their self-respect (Gibbs, 1988) (Minlker, 1989).

Therefore, one of the most important issues is related to the preparation for retirement: both physically and mentally. Robert Pamlin, 77, former head of the Georgia-Pacific Corporation, prudently began plotting his retirement plan ten years before he reached his company's mandatory retirement age in 1976. On his 65th birthday, he bought a small sand and gravel company in Portland. Ten years and two other acquisitions later, he oversees a small empire with revenues of $420 million (Toufexis, 1988).

Another good example is Leroy McDowell, 77, who is a retired CPA with 40 years experience in accounting. He helps a local restaurant business with their bookkeeping system as a volunteer. He remarks, "one cannot retire and sit around the house. I feel that I can go out and help the small business man or woman who cannot afford to hire a CPA to give them financial advice. . . ." This explains a lot about the important benefit of the expertise of retired people to new businesses and

non-profit organizations (Allen, February 27, 1989). It is good evidence showing that adjustment to retirement by both the elderly and the community is related in a significant way to the anticipation of retirement.

It should become common to come across the adverse effects of information given by doctors from different departments of medical schools in courses of preparation for retirement. Perhaps the anticipation of retirement should also include the possibility of disease, as long as this information could be given together with references to the frequency of the disease. And it should be supplemented by an accurate portrayal of the majority of old people and their competence in dealing with their problems. Even if we try to revise expectations arising from an excessively narrow medical emphasis on illness, we must still confront the effects of lifelong socialization to conform to age norms influenced by the negative image of aging. Therefore, we may state that the longstanding effect of all preretirement training approached will also be dependent on a revision of the general and the specific and individualistic

stereotype of the aged.

One of the theories that supports a high level of social activity to personal satisfaction is the "Activity Theory." Recognizing the fact that norms encourage old people to disengage from society whether they want to or not, the activity theory suggests the elderly should or may try to remain socially active by substituting new activities for those they have lost. The implication is that the old people do not differ in any significant way from younger adults: they evaluate themselves according to the same cultural norms. Because American culture has traditionally emphasized the value of being productive, we tend to base personal satisfaction on productive activity. Growing old is not likely to radically change an individual's culturally-based values and attitudes. As a result, the elderly are likely to find the absence of activity and responsibility just as unsatisfying as younger adults would. Of course, some elderly people welcome the opportunity to disengage to some degree. Therefore, the activity theory suggests that old age must be viewed as a highly variable stage of life, reflecting the distinctive needs,

interests and physical abilities of particular individuals (Macionis, 1987) (Activity Theory/Developed by Friedman & Harvighurst in 1950s).

Although defined by the chronological process of aging and the essential characteristics of each stage of life cycle, the socialization process considers distinctive characteristics of the individual, which may not be experienced by those living in other times and places. And each period of the life cycle presents characteristic problems and transitions that involve learning something new and, in many cases, unlearning what has become familiar. Socialization is thus not confined to any single period in life, but is a lifelong process of interaction between an individual and the larger society.

The current public belief that we can pursue any life style and at the end health maintenance will stand ready with a pill or operation to absolve us from a lifetime of abusing our bodies is indeed a myth. This belief is not fostering a service to mankind. A major responsibility for good health will always remain with the individual but the

understanding of how this may be achieved is the responsibility of science and medicine, while society must provide the means and environment in which optimal health may flourish. To learn more about the clinical manifestations of aging, for example, incontinence, mental confusion, postural instability, and mobility and to understand and study more fully the complex causes of depression in the elderly, the multiple pathologies, and their correlation with social factors are the principal goals of health education (World Health Organization, 1983).

Permanent education with the participation of all generations ought to lead to an attitude towards life as well as towards death. To make the advance into old age coincides with the need to develop a view of the meaning of existence, such as the task proposed for each. To educate is sometimes more important than to cure, since the possibility of a positive experience of old age is not only conditional on illness (hardship on recovering from illness always accompanies old age), but also on tolerance towards the illness on the part of the individual and the community. Concentration solely

on the elderly would not get to the roots of the problem. Education should be about physiological and pathological aspects of aging and how to modify the effects of these. Specific information should be made available about the local rules governing the provision of the resource on physiology and pathology of aging, how to get it, what it is like and where to go to get more information locally. Additionally, exploration of the strengths and weaknesses of the aging process should be considered by the elderly, both before and during retirement; all those people making decisions about the care of the elderly either as individuals locally, nationally, or internationally; and the general public beginning with education in schools and continuing throughout life. A life span view of human aging stresses the importance of the earlier years. The need was noted for dynamic learning through the life span, so that every age experiences and enjoys learning, creative activity, work service and leisure. Older persons especially need to have learned improved coping styles, autonomy, self-help, and self-realization. So far, gains in adult education generally tend to be enjoyed only by those

who are already educated, and thus have widened educational gaps between the educated and the non-educated. Aging is always a process to which a human is subjected but one also must interpret and manage its process. Human should not passively play out the aging process, but should give meaning and dignity to it.

Chapter IV

Health Care Issues

Medicare Reform and Longterm Care

Looking at the future, the formidable obstacles to achieving full access to healthcare for either the old or the young must be recognized. In recent years, healthcare has been moving toward a two-class system, one system for those who can pay the growing costs, and another increasingly limited system for the poor and near poor. Millions of poor people are frozen out of private insurance. The policy of the competition has not slowed the tendency for medical costs to rise much faster than inflation. And cost sharing and the privatization of Medicare through the purchase of vouchers (a plan by which elders would be given a specified amount of "credit" and sent on their own into the private market to find and purchase their own care) continue to be touted as the solutions for the health problems of the elderly. Social organizations that focus on an aging society that is controlled by financing and

delivery mechanisms with a broad range of services, has little concern about the misuse of cost-ineffective technologies. There will be a doubling of real healthcare spending before the baby boom population needs to use the system (Estes, 1988).

It has been observed that politics determine how old age is defined in our society and the material conditions for the existence of the elderly. It is also clear that the nation's elderly cannot afford to bear the burden of their further erosions in Medicare benefits or increases in out-of-pocket medical expenses. The aging of society requires action. So also does the growing recognition of the unacceptable results of our nation's approach to the rationing of healthcare, the uninsurance of more than 37 million Americans under age 65, and the underinsurance of more than 27 million elders for chronic illness and long-term care (Dentzer, 1988). Both the elderly and those who support their health insurance should be provided with access to healthcare, including longterm care, and incentives for a fair and equitable distribution of the nation's resources in health.

Under the current Medicare program about one half of healthcare expenditures are covered. Medicare excludes coverage for longterm care, drugs, dental care, eyeglasses, hearing aids, preventive physical exams and other important services for the elderly. Medicare's coverage consists of hospital care (70 percent). The major health policy issue is the rising cost of healthcare and the need for the provision of longterm care. Recently changes in the Medicare policy, particularly the introductory part, were suggested for the next few years. The idea is that the new law expanding Medicare coverage should save the elderly's money and, until all the benefits are fully available in 1993, the gaps can be paid by the elderly themselves or be covered by private insurance. The following table shows what changes will take place (Pamphlet issued by Department of Health and Human Services Health Care Financing Administration in 1988).

* Hospital Benefits have been improved.
* Annual limit has been placed on the deductibles and copayments you have to pay.
* A new prescription drug benefit has been added.

Old Medicare Plan

Hospital Benefits (Part A):

* You pay $540 deductible and Medicare pays balance of all allowable charges during first 60 days of hospitalization per "benefit period." There is a daily copayment of $135 for the next 30 days, and after 90 days of hospital care for an illness or injury you pay all costs unless "reserve days" are used. There is no limit on your out-of-pocket expenses.
* 100 days skilled nursing facility care per "benefit period."
* Unlimited home health care for up to four days per week, and up to three weeks of care per illness, five or more days per week.
* Hospice care up to 210 days.
* No custodial nursing home care.

Medical Benefits (Part B):

* You pay $75 deductible.
* You pay copayment of 20 percent with no limit on out-of-pocket expenses. Medicare pays other 80 percent of allowable charges.
* Prescription drugs not covered.

Part B Premium:

* 1988 premium is $24.80 per month.
* No supplemental premium.

New Medicare Plan

Hospital Benefits (Part A):

* You pay an annual deductible of $564 (estimated for 1988) and Medicare pays the balance regardless of the number of days of hospitalization or the cost.
* 150 days skilled nursing facility care per year.
* Up to six days a week of intermittent home health care; up to 38 days of daily home health care.
* Hospice care beyond 210 days recertified as terminally ill.
* No custodial nursing home care.

Medical Benefits (Part B):

* Beginning January 1, 1990, you pay $75 deductible and 20 percent copayment. After deductible and copayments exceed $1,370, Medicare pays 100 percent of allowable charges for remainder of year.

* When fully implemented in 1993, Medicare pays 80 percent of prescription drug costs above $710; in 1991, Medicare pays 50 percent of costs above $600. Some drugs will be covered in 1990.

Part B Premium:

* Besides the regular annual adjustment, the basic Part B premium is increased $4 a month to help cover the cost of the new benefits.
* Supplemental premiums adjusted to taxable income.

Proposed changes in Medicare will relieve some of the burden of the elderly, but rising taxes in the near future and the bulk of longterm care will create added pressure on home and community care givers. With the growing trend of outpatient surgery and other medical procedures, longterm care and nursing home care are not considered at all. The elderly are experiencing increased health costs to the extent that they require posthospital care and supportive services not covered by Medicare. A particularly difficult problem is that Medicare's extremely limited benefits for homecare have become

even more restricted just when early hospital discharges and out-of-hospital procedures increased the need of many patients for these services. For financial suppporters, taxpayers and family members of elderly parents, the financial situation is not optimistic about the changes in Medicare. First of all, the improvements of Medicare services will increase taxpayers burden of paying higher taxes. Then, if a budget cuts proposal in healthcare passes the law and the tax increase stays low, and they are still required to pay higher spending on medical bills for their parents. Carroll Estes says that currently, one out of every 50 persons between age 65 and 74 require longterm care. One out of every four persons over age 85 is placed in a nursing home. A semi-private room in a skilled nursing home costs $60 per day, or roughly $22,000 per year. Thirty years from now it is estimated that it will cost about $55,000 per year. Then all but the rich will be wiped out from nursing home stays. Also industry experts estimate that the cost of longterm care will ruin 70 percent of all single people admitted to a nursing home within three months and 50 percent of all couples within six months after

one spouse is admitted (1988).

Jordan Goodman advises that health insurance is attempting to provide private protection. Including plans for group longterm policies, there are approximately 80 individual longterm care policies available on the market today. But proliferation of longterm care policies has produced a crazy quilt of charges, inflation riders, waivers and limitations which often inhibit the consumer to buy. At the same time, many health care benefit consultants and other health care experts are not convinced that you should buy, and even those who are in favor of purchasing longterm care coverage do not agree on when to purchase it (1988).

The fact that many people who are put in nursing homes quickly spend down their assets and life savings and eventually end up on Medicaid often means a move to Medicaid-approved nursing homes. Medicare currently pays about $36 a day for intermediate care and $45 a day for skilled care. The burden has been shifted to the individual to select a longterm plan. Numerous companies are offering benefits of varying stripes. Some cover only a part of nursing home care and others provide

extensive coverage for home-provided health services unrelated to an acute condition. Because of an absence of reliable actuarial data, however, most insurers have been hesitant to enter the fully covered longterm care insurance market. Also, this attitude has been accelerated by uncertainty about the federal role, especially since the new proposal of extended Medicare coverage as a form of catastrophic health insurance. Private insurance coverage is critical to facilitate the development of services that beneficiaries want, but does not ensure that quality services will be developed to meet the new demand or that the appropriate range of services will be developed (Miller, 1988).

Policymakers need to address the broad implications of health and social policy initiatives that affect the elderly's ability to attain the optimal balance between the goal of least restrictive environment and efficient service delivery mechanisms. Policymakers must also try to achieve access, cost containment and quality goals such as supply restriction, eligibility assessment and quality assurance that is independent from one generation to another. Given the complexity of the

patchwork of policies that affects longterm care services, it is imperative that we begin to examine the configuration of forces that can alter the intended effects of policy initiatives.

Charlotte Grimes says in the St. Louis Post Dispatch that last year more than 100 longterm care bills have been dropped, while Congress is planning to discuss additional proposals on longterm care. Passage of longterm care legislation is one of the most pressing problems we face. Because of the federal deficit, enough concerns for growing pain of the aging population and its supports are not paid. These people require more nursing home stays, home health care services and a range of other support activities to allow the sick or disabled to live without much worry about financial security. There is no comprehensive program for providing longterm care or for paying the exorbitant cost, and there will never be, if the current administration stays on the same basis. Nobody in the 21st century will enjoy the golden age, unless they are very rich and relatively healthy (February 1, 1989; 7A). Ernest Hollings said that in 1988 the former president's administration proposed its final budget plan that

produced a deficit of $120 billion, far above the limit allowed by law. His replacement, George Bush, has said that Reagan's blueprint of the proposal will be revised. Nonetheless, the budget office's examination of Reagan's budget plan is significant because Bush is expected to incorporate major portions of his predecessor's spending plan into his own. When a proposal of a freeze on spending failed in 1983, the Gramm-Rudman-Hollings Deficit Reduction Act to cut spending was to be applied to prevent the Reagan administration from splurging the nation's money. At first this worked; government has succeeded in reducing the deficit in substantial increments each year from $221 billion to $155 billion. For 200 years of America's European immigrants' history, for 38 presidents, and for the cost of all the wars, the combined national debt was only $909 billion. After eight years of Reagan's administration, the debt has just about tripled to $2.6 trillion with interest costs this year of $182 billion (1989).

Reagan's lack of control over his administration wasted our taxes, and billions of dollars in interest--estimated up to $182 billion in

1989 and to $192 billion in 1990. Those billions could have been used for gainful purposes such as the improvement of education, research, cleaning up the environment, raising America's morale, providing shelter for the homeless, increasing cancer research and so on. What Reagan calls "retarded people," those who are homeless Americans staying at federal-supported shelters, were not provided with adequate help. During a few years before and after the 1984 election, he failed to propose appropriate tax increases. Also, he failed to pay the bills at an appropriate time. His mistakes increased the interest cost by $130 billion annually. For Bush, it is like starting a new spending program of $130 billion for nothing, a program that cannot be cut and must be paid and is bound to increase each year (Hollings, 1989).

Federal Deficit and Health Insurance

Charlotte Grimes discusses the plight of the 37 million Americans without health insurance, of which about two-thirds are workers and their families.

According to Grimes, the need for longterm care for millions of disabled and elderly will be high on Congress's agenda in the next ten years. With the government staring down the gun barrel of the federal deficit, both issues are likely to get mostly talk and not much action. A broad range of critical health care issues will continue to get short-shrived in the face of the federal budget deficit. Reform of the health care system will be most likely postponed. As a health care problem, the need for coverage of those without insurance will be the highest on the national agenda. Traditional Robin Hood payment systems, under which hospitals charge higher bills to those who have insurance to pay for those who have not, is decreasing because of cost conscious corporate consultants and insurance companies (February 1, 1989:1B).

Susan B. Garland said that starting this year, corporations may be asked to pay a stiff price for their employees' ever-widening health benefits. Thanks to tax reform, companies will have to ensure that health benefits are distributed equitably among all workers. Otherwise, corporations will have to

overhaul their health plans, and higher paid workers receiving the disputed benefits will be hit with a tax penalty. In 1986, when Congress adopted a measure barring plans from discriminating against lower wage workers, this plan was suggested to pass into law. According to lawmakers, health benefits which are tax deductible to companies and cost the government $36 billion a year in lost revenues are a form of wage subsidy. This insists on having companies provide their low- and middle-income workers with an equal share of health benefits; however, in practice they pose several hurdles for lower paid workers. The new law ignores workers' reasons for choosing benefits. Well-paid executives, for example, could fork over the extra premiums for family coverage in a typical plan whose cost might be beyond the reach of entry-level and middle-income workers (October 3, 1988).

Garland adds that for physicians the pain starts in their wallet. Every time they see a Medicare patient in their office for a routine checkup, the federal government only pays 70 percent of the customary fee. Medicare currently treats surgeons well. Congress is expecting to increase

reimbursements for physicians who rely on their diagnostic skills. But the proposal is already giving even surgeons heartburn. For some high-cost surgical specialties, Medicare fees could be cut by up to 30 percent. If payments for services would be cut, surgeons could compensate by charging private patients more. Employers, whose bills for physician costs have risen by 12 percent a year, could see their premiums climb even higher. Lower Medicare payments for costly surgery could fuel increases in employer-paid retirement health benefits, unless the stabilization of their rates would occur. Medicare officials would like to correct payment inequities, but one reason costs are rising is that physicians are performing more tests and surgical procedures. And if disbursements for tests and surgery are cut, doctors may well respond by doing more (July 18, 1988). Charlotte Grimes also discusses in the St. Louis Post Dispatch, that "Hospital costs and doctor's costs overall have been rising faster than the general inflation rate. Many health-care analysts attribute some of the skyrocketing cost of medical care, now about $550 billion a year, to the increases of fees charged by hospitals and doctors

(February 1, 1989:1B).

Susan Dentzer reports that deficit reduction, 5,600 hospitals, half a million physicians, 33 million Medicare beneficiaries and their lobbyists in Washington all hold a huge stake in the $90 billion health program for the aged and disabled and could turn a fight over Medicare cuts into a major political battle this year. The stiffening resistance to slashing Medicare and the opposition to a proposed $1 billion cut in Medicaid could make it difficult for Bush to meet deficit reduction targets without deeper cuts in other programs. The costs of the system are out of control. The aging population and high-cost technology mean Medicare outlays could grow a staggering 51 percent from fiscal 1990 to 1994. About half of all hospitals are losing money on Medicare. More importantly, there is a maldistribution of hospitals, beds and doctors, with relatively few in some areas and too many in others. Legislators also worry about the impact of cuts on beneficiaries. Besides having to pay higher premiums, some of the elderly may lose access to needed, quality health care, especially as rural and inner city hospitals continue to close.

The hospital portion of Medicare constitutes two-thirds of the program's spending, and budgeteers have found it fertile ground for savings. Because of costly medical equipment purchases and questionable expansion; however, hospitals as a group just broke even on Medicare in 1988. A proposal to cut Medicare could save $1 billion in fiscal 1990 but also could curb a subsidy that helps pay for the complex cases. Another plan would slash by $1.6 billion Medicare payments that help hospitals defray interest and depreciation on equipment and new construction. Overall Bush is proposing a $5.5 billion cut in the projected growth of Medicare. But simply cutting back on the program once again will amount to curtailing services to the very people that the administration presumably wants to help. His proposal might even make more doctors and hospitals reluctant to treat certain Medicare patients because of low reimbursements (February 6, 1989).

The concept of longterm care is the delivery of medical, personal and social services to persons who have impaired functional capacities. A major objective is to keep the patients at their highest

possible level of functioning and to provide continuing care in the least restricted environment. Coordinated care programs with easy access to those eligible and qualified, should be achieved. Unfortunately, however, there is little shared understanding of the issues involved in developing longterm care policy. Consumers and policy makers are unhappy about the existing system. A variety of options ranges from home health services provided in one's own home, to medically-oriented congregate housing with independent apartments or restrictive residential facilities providing care and supervision. The unique aspect of longterm care services is that they are inextricably tied up with housing arrangements (Callahan, 1987).

The medical and the social definitions of care is that longterm care recipients tend to have chronic diseases and require intermittent hospitalization and need residential and continuous home support services after the acute condition is controlled. The relationship between a person's level of physical functioning and the need for assistance with instrumental and personal care should be implicated to achieve the optimal balance

between residential restrictiveness and the support necessary to meet elders' service needs. The optimal mix of residential setting and functional dependence can be seriously compromised if the care provided, whether in an elder's home or apartment or in a nursing home, is of poor quality. In addition to the establishment of the appropriate balance between residential arrangement, community service and family support, the quality and coordination of those efforts must be assured. The success of such programs largely depends on the availability of alternative community services and the cost-effective maintenance at home. Without sufficient community support, the optimal balance between functional dependence and the restrictiveness of the residential arrangement cannot be reached. The expansion of community-based programs should be designed to substitute for dependence on institutionalization and to reduce the cost of longterm care. Process of community care as well as service components of longterm care should be measured to increase the ability of community settings as an assistant provider. Appropriate policy on the allocation of service to all the

needy, including the young and old, can be established to distribute resources equally.

Chapter V

CONCLUSION

Equal Distribution of Resources

Medical technology as the relief of chronic disease, understanding of the meaning of aging and the impact of one's death, and public and governmental assistance should be viewed for the benefit of society. Elimination of anxieties about growing old is the indispensable duty of the whole society. Current problems of the aging society were initiated with an increase in life expectancy. Between 1980 and 2040, a 41 percent general population increase is expected; 160 percent of that is expected for persons 65 or older. The population of those 85 or over will increase to 5.1 million in 2000 from the 3.4 million projection in 1990. The number of those who are age 65 or older will increase from 31.7 million in 1990 and 35 million in 2000. In 2040, it is estimated that 21 percent of the 65 or older population will require almost one-half of health care related expenditures (Callahan, 1987).

Chronic diseases will become common among the 85 or older population. It means a substantial increase in the need for medical care. Demographic and economic trends in the next few decades will make it very difficult to keep up with the increasing need of assistance. When considering the unexpected technological changes and health consciousness of the future elderly, we must predict that the gap between health care needs and limited financial resource will cause more serious problems. However, these negative expectations of the future trend might be too diverse to make a meaningful exercise come true. It also contributes to a stereotyping of the old and a consequent failure to attend to the specific needs of each individual and subgroups among the aged.

The demographic changes indicate the necessity of reformation of social and governmental policy and strategy. It is not deniable that the costs of health care delivery combined with a growing old population will substantially increase costs of medical and daily care for the elderly. Additionally, whereas stereotyping the elderly by their chronological age is easy to administer,

currently no given measurement is appropriate to any given individual. There is a need for coordinated strategies on the heterogeneity of the old population. Increasing costs of medical care and health care support by the government do not always indicate the improvement of health care. Expensive laboratory tests, operations, procedures and intensive care of terminally ill patients might have to be cut back, if they are unnecessary costs based on one's health maintenance. The effectiveness of diagnoses and treatment of illness among medical personnel should be developed. The costs of hospitalization under Medicare and the following outpatient surgical and other medical procedures have much room to be reduced.

Currently the health care system has no designs to allocate limited resources among health and other basic needs. Nor does a reduction of spending on the elderly promise that the money will be used for other meaningful purposes. The lack of coordinated health, welfare and social planning mean incentives for the pursuit of its own interests. For example, it is suggested by some medical economists that control of the costs of the dying elderly would eliminate the excessively heavy health care costs of

that age group. While it might settle the moral issue, an appropriate balance between care of the dying and health services for the rest of the population probably is a legitimate topic to be discussed. According to Daniel Callahan, 25 to 35 percent of Medicare expenditures goes to five to six percent of the elderly who will die within that year. Additionally, the costs of caring for the dying is often much higher than for those who survive (1987). While these statistics support the problem of the care for the dying, there is a question about whether physicians are capable enough to judge that a person is dying even with appropriate medical care.

Continuing technological refinement of medical therapy leads to the changing expectations of needed allocations. Medical need, for example, is not a fixed concept, but is a combination of technological possibility and social expectations. For most of the aged, the avoidance of physical decline and the suffering from death explain their expectations of medical need. If health care is an access to medical technology that helps people live out a natural life span without suffering, it is not fair

to use a person's age as the only basis for providing health care. It is because health care, in relation with other social environments such as education on aging process, impact of emotional issues of aging family members and roles of the elderly within society, must be used as a way to prevent the loss of the meaning of growing old. All the generations should then be provided with the same amount of support according to their level of need (both medical and emotional), not when they get to a certain age. The overall welfare of the generations, the proper function of medicine, and a fitting understanding of the aging process and death should be equally emphasized to people in all stages of life's course. The degree of satisfaction of each individual is what creates the satisfaction of the whole society.

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