Frontiers of Service to the Aging*

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The (future) gains in life expectancy will be accompanied by a great increase in dependency at the end of the life span at 75, 85, and 95! Within the Jewish community, the aged will require more attention than ever. Our communal services—all of them—will need reorientation toward the aged.

We are engaged in a titanic struggle to defend the great social insurance programs which sustain the lives of more than 25 million older Americans. These programs and a great network of health and welfare services which have extended the life span of older people so dramatically are gravely threatened. There is cause for concern. Inflation has eroded the value of hard-earned pensions and lifetime savings. The growing fury of the attack on social security, Medicare, Medicaid, food stamps, the Older Americans Act, and Social Services block grant programs which indeed provide a "safety net" for older people, is alarming.

Despite the pledges of candidate Ronald Reagan, and President Ronald Reagan to protect the "social safety net," it is evident that the proposed budgets for FY 1983 and FY 1984 call for severe curtailment of older American programs.

On March 31, 1982, Lillian Kandel, a seventy-year old vice-president of JASA of Young Israel, and the author testified before the Select Committee on Aging of the House of Representatives in Washington on the devasting effect of the proposed eighteen percent cut in the Community Service Block Grant, effective October 1, 1982, on the JASA services. Mrs. Kandel, a retired nurse and widow, described the anguish of the elderly in the Parkchester area of the Bronx whose JASA center had been threatened with closure, a consequence of budget cuts. A well organized campaign of the Joint Public Affairs Committee, an older adult coalition of senior citizen centers, of which Mrs. Kandel is a leader, succeeded in averting closure. State and municipal funds were found to continue service.

At this hearing, Assistant Secretary Dorcas R. Hardy, of Health and Human Services, and Dr. Lennie-Marie P. Tolliver, Commissioner, Administration on Aging, asserted that the voluntary philanthropic community would make up the reduction in federal grants for services. The author testified to the inability of voluntary philanthropy to close this large gap. The agency, relatively well funded by the Federation of Jewish Philanthropies of New York, faced a loss of about one million dollars, twenty percent of $4,000,000 in social service grants, with reductions in the Social Service Block Grant, and Older American Act funds. Not even an unprecedented twelve percent increase in its Federation grant, $180,000 over the $1.5 million received in 1981-82, could make up so severe a loss.

The historic conflict in Washington, D.C. and in every state of the union comes at a time when older people, as never before in history, can look forward to a longer life, in better health, and with greater opportunities for fulfillment. The 1980 census data records 25.5 million Americans over 65, 11.3 percent of the population, more than double that of 1930, just 50 years ago, and quadruple that of 1880. In 18 years, by

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the year 2000, the population over age 65 is expected to be at least 32 million, but may reach 40 million. With continued reduction in mortality rates, the fastest growing segment of the aged population is the cohort over 75, almost one third the elderly, and the 85's and older, 10 percent of the elderly. At age 65, the average life expectancy in 1980 was 16.4 years, men could expect 14 years, women 18.4 years. Despite the promise of age, the elderly population has grown more diverse.[1] The need for financial security, for continued employment, adequate benefits, good health care, appropriate housing, and constructive activity and engagement of this large aged population is universal. Among the aged, particularly the middle-old from 75 to 84 and the old-old from 85 and over, there is a vastly increased incidence of physical and mental disability, isolation with the loss of a spouse and other aged contemporary relatives and friends, physical distance from relatives, and lower income. A majority of the elderly are women and more likely to be poor or near poor.

Advocacy

All of this suggests the first major frontier in the field of aging, for all women and men of good will, and the elderly themselves.

The first frontier in aging is a commitment to a program of continued advocacy in the public arena on behalf of the elderly.

As a Jewish community we have a particular, historic concern for the aged. Our institutions and agencies have for so long been the pioneers in service development and standard setting. Our lawyers and professionals have led the field in securing enactment of progressive legislation.

Every Jewish Federation, community council, social agency, community center, synagogue, adult organization, and senior center club should have an active public affairs committee concerned with legislation affecting the elderly at the federal, state, county and municipal level. A community wide Jewish Action Council on Aging can join with other concerned organizations in a common effort on behalf of the elderly. Great emphasis should be placed on involvement of the elderly. The active role of the older person as advocate is a worthy model. Indeed, in Metropolitan New York, the Joint Public Affairs Committee, a coalition of more than 120 JASA, YM-YWHA and other senior centers have become a formidable political force. Action memos and a newspaper, borough and city-wide councils, and a vigorous program of communications and personal visits have caused legislators to be concerned with the interests of so active a group of voters.

On a national basis, Jewish involvement in communities in the South, Midwest and West would greatly strengthen this national coalition of the elderly. We plan to convene an all-day Consultation on Legislation of the Elderly next fall, in cooperation with our Federation and the Council of Jewish Federations.

Only if we can assure the continuity of our major social insurance and service programs for the elderly, shall we be able to go forward to consider other frontiers of service in aging.

Planning and Organizing

Aging has particular Jewish dimensions. Both the joy of long life and *nachas,* and the pain and anguish of the disabilities of age. There simply are proportionately more older Jews than people of most other faiths or ethnic backgrounds.

Sidney Goldstein estimates the Jewish elderly over 65 to number 700,000, 12 percent of the national Jewish population of 5.8 million in 1979. With the continued decline in the birth rate of Jewish families, the median age of the Jewish population is

[1] *Developments in Aging: 1981,* Volume 1, A Report of the Special Committee on Aging, United States Senate. Rept. 97-314, Vol. 1, pps. 1-36.

significantly higher than the general population.[2]

In a study of the Status of the Jewish Elderly of Greater New York, completed by the author and Dr. Abraham Monk in 1980, the Jewish aged population of this metropolis was estimated to be 263,150, 13.1 percent of a population of 2,013,650 in New York City, Nassau, Suffolk and Westchester counties. But in New York City, the percentage of aged Jews is estimated to be 18.6 percent of the Jewish population, and as high as 34.2 percent of the Jewish population in the Bronx.[3] Although New York may be the largest gerontic community in recorded Jewish history, there are now many Jewish neighborhoods throughout the country, beyond Florida, and areas which have take a distinctly greying tinge.

The Allied Jewish Federation of Denver, in completing a demographic study of its Jewish population in 1981, found 11.5 percent to be over 65, of which 7.7 percent were 65-74, and 3.8 percent were 75 to 94. This, in a young western community over half of whose households moved into Denver during the last ten years.[4]

Parenthetically, Jewish longevity is attributed to better prenatal and child health care, stable family life and lifestyles, sheltered occupations, residence in urban communities, and genetics.

It is among the middle-old, the 75-84 year olds, and the old-old, those 85 years of age and older that the greatest incidence of the complex health-disability and social problems of age occur. The impact of these problems upon the older person and his family can be devastating. And if the elderly population in the community is substantial, every social agency and institution will be overwhelmed by demands for assistance. Moreover, a higher proportion of the Jewish aged are beset by problems of poverty, bad housing and residence in changing, high crime areas. The exodus of Jewish families to the suburbs aggravated the plight of the Jewish elderly left behind in the inner city.

During the past two decades, the notable initiatives of Jewish Federations in organizing new, multi-functional agencies and intra-agency coordinating committees to develop and increase the provision of comprehensive services to maintain the aged in the community, and to establish new and innovative services were an effective response to the epidemic of aging . . .

The Jewish Association for Services for the Aged, established in New York City in 1968, and the Council for the Elderly in Chicago in 1970, are examples of new agencies. Jewish family service agencies increased their services for the elderly, who comprised over a third of the clients. Homes for the aged increased the number of their beds. Since 1964, Jewish agencies have produced many new housing units for the elderly. By 1978, seventy-five housing facilities with 11,500 apartments were sponsored by Jewish organizations. An additional 35 projects, sponsored by Jewish homes for the aged, multi-functional agencies and community centers have been authorized by the U.S. Department of Housing and Urban Development. Jewish community centers, vocational and counseling agencies, have substantially increased their services to the aged. The burst of effort initiated during the seventies was fruitful, and the momentum of increased service continues.

The single major trend, the notable

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[2] Sidney Goldstein, "Jews in the United States: Perspectives from Demography," *Amercian Jewish Yearbook, 1981*. New York and Phila.: American Jewish Committee and Jewish Publication Society of America, pp. 3-59.

[3] Bernard Warach, and Dr. Abraham Monk, "The Status of the Jewish Elderly of Greater New York and Recommendations for Action, 1980," Jewish Association for Services for the Aged, New York, 1980.

[4] *Currents,* Vol. 3, No. 2, March, 1982, Allied Jewish Federation of Denver.

increase in the number of middle-old and old-old people now requires great attention.

The over 75 age group is growing at twice the rate of the 65-74 group. Most now reside in their own homes, not institutions. They suffer an increasing incidence of critical or near critical conditions. As their morality rate decreases, their morbidity, or actual vulnerability increases. There is a higher incidence of survival of women, most of whom live alone. They are often shut in because of functional or physical impairments, fear to venture outside. By age 85, one of every two older persons will require some home-care services to survive. All too great a number live at a distance from adult children, or have no child or friend to help. It is for this group that the new frontiers of programs are especially needed; medical and dental care, home health-care, day centers, enriched housing, case management, conservatorship, legal guardianship, and protective services are among the forms of service devised to assist this vulnerable group. Many vulnerable frail Jewish elderly are not touched by outreach services, or have no access to publicly funded programs. Many of the Jewish elderly have income and resources just above the Medicaid and SSI eligibility level. These elderly people especially need Jewish communal support.

The recent emergence of this large cohort of middle-old and old-old suggests the second frontier.

The second frontier is an old frontier, the renewal of a planning effort by every health and welfare agency and Jewish Federation to assess the status of the elderly, strengthen old programs and services, and develop new programs.

Priorities in allocation of philanthropic funds for the elderly must be reconsidered. It can no longer be assumed that the government will provide substantially all the needed funding of basic services.

In New York City, the Federation of Jewish Philanthropies has reconstituted its Community Services Committee to represent the broad circle of concerned agencies to develop a plan for services for the elderly in the 80's. Because so many of the problems of age require close cooperation of health, welfare, legal services, the synagogue and family, no single agency can deliver all of the services needed by the vast elderly population in the community. The guidelines to program planning and development to meet the needs of the elderly set forth in the 1977 article, "Matching Services and Activities to Meet the Varied Needs of Older People," have been tested by experience and should be useful in this renewed effort.[5]

Education and Survival for Longer Life

We find several generations, the middle-aged in their 50's and the young-old in their early 60's who know little of the opportunities, and the trials and tribulations of the three decades, the sixties, seventies and eighties, most persons will survive. A spate of literature on planning for retirement is mostly concerned with finances and relocation to sunny climes. As practitioners we have had to become gerontologists. There are now vast research findings which can provide a deeper understanding of the physical, mental, social, emotional, economic and cultural aspects of growing older. Indeed, the upcoming generation of older people, with far better education, is ready to absorb new knowledge and insight.

There is the need to learn about available services and facilities, the use of government and private insurance, and complex laws and bureaucracies to be managed. Communal workers are familiar with the severe emotional problems of the elderly and their

[5] Bernard Warach, "Matching Services and Activities to Meet the Varied Needs of Older People," Graenum Berger, ed., *The Turbulent Decades, Jewish Communal Service in America, 1958-1978.* New York: Conference of Jewish Communal Service, 1981, pp. 217-229.

children, and the intergenerational conflicts in coping with age. Once before, during the late forties and fifties the post World War II generation turned to Dr. Benjamin Spock for guidance. In 1982, new guidance is needed for the coming of old age.

There is clear scientific evidence that health can be improved and life expectancy increased with a better life style determined by each person. Reflecting this finding is General Health, Inc., a health information company based in Washington, D.C. and organized recently to provide "A Health Risk Profile" and customized health education service for individual organizations and corporate health programs.[6]

The author's recent work, *The Older American's Survival Guide,* provides prescriptions for better health that affirm the crucial role of personal life style, habits and self-care in maintaining good health and a longer life. Chronic diseases are described, as are ways of coping with the problems of aging. Home care and nursing services are discussed, as are ways of paying for health care through Medicare, Medicaid and supplementary health insurance.[7]

The third frontier area lies in the organization of an educational program for the Jewish community on "growing older."

Many family agencies, homes for the aged, private practitioners and large business corporations have established programs ranging from one-time lectures to extended seminars in pre-retirement counseling. The public has learned about aging, how better to use community and personal resources to buy needed services.

The educational program has been a contributing element in the profound changes in patterns offering home care. The age of admission to nursing homes, now at 84 in New York City, up from 78 in 1968, reflects the greater capacity of the population to cope with the crisis of aging at home. The continued contacts of the mature and aging population with family agencies and JASA has had a perceptible effect.

The programs should be planned as a vigorous public health educational campaign. There is now a cadre of able professionals, social workers and health administrators in Jewish communal agencies which can mount such a program. Teaching materials are available from government and national health and welfare agencies.[8]

The Need for Adequate Social Work Service

The fourth frontier is in the adequate provision of social work services for the elderly under Jewish communal auspices.

Coping with the many crises of aging has overwhelmed many of the elderly and their families. Since the enactment of Medicare, Medicaid, the Older Americans Act, and sundry other programs, there has emerged a great array of health and welfare entitlements. These programs can provide enormous benefits, but access comes through a chaotic triangle of bureaucracies and processes. Skilled workers, let alone an anxious or depressed elderly person, find these systems difficult to manage. The need for social service for the elderly within the Jewish community continues unabated.

As the general educational and income levels of the Jewish elderly increase, they will especially require knowledgeable, skilled counsel. In Metropolitan New York the counseling services for the elderly under Jewish auspices are understaffed as I believe they are throughout the country. Overall,

[6] General Health, Inc., 1046 Potomac Street, N.W., Washington, D.C. 20007.

[7] Bernard Warach, *The Older American's Survival Guide for Better Health and a Longer Life.* Englewood Cliffs, N.J.: Prentice Hall, Inc., 1981.

[8] *Healthy People, The Surgeon General's Report on Health Promotion and Disease Prevention,* 1979, U.S. Department of Health, Education and Welfare, DHEW Publication No. 79-55071.

approximately 90 social workers are available to serve a population of 260,000 elderly people. Every year, one in five elderly Jewish people contacts the offices of JASA, the Westchester Jewish Family Services and its sister agencies for assistance. Caseloads exceed 60 on average and intake is frequently closed. This is not a problem unique to New York City. Certainly Miami, and certain other communities with significant numbers of poor elderly Jews, must experience these problems.

While an increasingly middle-class elderly population and their families may be able to pay a greater share of the cost of short term, problem oriented counseling, the principal source of funding social workers for the elderly will be the United Jewish Appeal. Greater allocations must be secured to fund this critical area of need.

Comprehensive Diagnosis, Case Management and Protective Services

The fifth frontier lies in the development of comprehensive diagnosis, case management, and coordinated home-care and protective services for the chronically disabled.

During this last decade a number of experimental programs have demonstrated the value of coordinated services of diagnosis, prescription and the provision of coordinated services through case management for the physically and mentally disabled.

The Monroe County (New York) Long-Term Care Program Inc. and Triage, Inc., Plainville, Connecticut tested the value of a rigorous, diagnostic workup prior to admission of clients into long-term care. The effectiveness of such assessment mechanisms in diverting high risk clients from institutional care to home care has not yet been proven.[9] Social agencies have assisted families, or have taken direct responsibility for the mentally impaired through use of such legal devices as the "power of attorney," "representative payee" authority under social security and other pension programs, the conservatorship and guardianship. The provision of protective services requires precision and an order of attention to legalities well known to child-care agencies which have long been "in loco parentis."

For the growing number of mentally impaired elderly people without kin or friends to assume these grave responsibilities, protective services are essential to prevent institutionalization. There has already been a great increase in the number of mentally impaired elderly who survive into age and who cannot immediately be institutionalized or who can be maintained at home. There are now numbers of elderly retarded persons who need protective services. Several agencies in scattered places have been able to utilize government funds for such services on a very limited scale or in demonstration programs. Despite the paucity of such resources, over the long-term, community care services will be found to be less expensive than institutionalization. Protective services will then be funded. Meanwhile, voluntary philanthropic support should be sought to demonstrate the usefulness of protective services and case management and to learn from the experience. JASA has served as conservator and case manager in protective services demonstration programs for the impaired elderly. These programs are expensive, complex and very worthwhile. They can maintain frail, impaired elderly at home.

A sixth major frontier lies in the development of home-care services for the impaired elderly.

Long-term now represents 13.5 percent of all health expenditures, $32 billion of $237 billion in 1980. These long-term care services are most often provided in a hospital or nursing home. As the percentage

[9] *Long Term Care, In Search of Solutions,* National Conference on Social Welfare, Washington, D.C., Fall, 1981.

of elderly unable to carry out the activities of daily living unaided increases from 14.4 percent among 65 to 74 years old to 32.9 for persons 85 and over, so too does the need for long-term care.

There were 20,185 nursing care facilities, with 1,407,000 beds in 1979.[10] Ninety percent of the residents were over 65. Total national expenditures for nursing home care, from all public and private resources exceeded $24.2 billion in 1981. By contrast, home health care expenditures reached a total of $735 million in 1980.

The number of institutional care beds—nursing homes and domiciliary care facilities grew from 836,554 in 1967 to 1,407,000 in 1976, and has remained almost unchanged since. Public authorities concerned with the steeply mounting cost of institutional care have imposed a *de facto* moratorium on construction of new nursing home beds. Moreover, since the nursing home scandals of the seventies, some of the profits in proprietary nursing homes have diminished. The cost of institutional care and construction of new facilities has skyrocketed. The national average annual cost per patient of $14,600 for a skilled nursing home is far exceeded in the New York Metropolitan area by costs of over $100 a day, $36,000 per annum, in some of our Federation affiliated nursing homes. Absent available beds, their high costs, and the growing ability of the elderly and their families to purchase home care services, it is no wonder the median age of admission and residence is now over eighty nationally and is in the mid-eighties in nursing homes in New York.

Institutionalization, we have learned, is the result of functional disability, and the lack or collapse of family or informal support and home care services. There are an estimated 1.3 persons in the community requiring the equivalent amount of care at home as there are nursing home residents. For the severely impaired and mentally disabled older person requiring care intermittently through a 24-hour period, institutional care will remain the most effective, even the most economical form of care. But the findings of a survey of studies of cost effectiveness of case management and home care services clearly indicate the economy of provision of long-term care services in the community.[11]

Some agencies such as the visiting nurse service have provided home health-care services historically. Others, such as homes for the aged, family and aged service agencies, have entered this field more recently. The "home care" alternative should now be understood to mean the full range of services. "Home Health Care," reimbursable under Medicare and Medicaid when provided by received medical providers or certified home health care agencies may include the services of: doctor, nurse, home-health aide, social worker, physical therapist, speech therapist and occupational therapist.

Personal care services are provided by home-health aides, or home attendants principally in support of the activities of daily living of the impaired client or patient. This care, too, may be paid for Medicaid eligible clients at home on a physician's prescription, and if approved by the appropriate public authorities. Some home-care service is funded by Community Service Block Grant funds, some by Older Americans Act appropriations.

Other forms of in-home services have become familiar. Homemaker and chore services include housekeeping, laundry, shopping, performance of chores, minor repairs, yard work, and may include some financial management. Family and children's service agencies have long provided such services, either as a direct function of agency staff or through purchase of service

[10] *Long Term Care, Background and Future Directions,* Health Care Financing Administration, HCFA-81-20047, Jan., 1981.

[11] *Ibid.*

arrangements.

In New York City such agencies as JASA, Self-Help Community Services, and the Westchester Jewish Family Services have developed large scale programs in the direct provision of home-care services. These services are provided under contract with the Department of Social Services of New York and Westchester County, and the Department of Aging of New York and Nassau County, by direct client reimbursement and as a grant of "in-kind-relief." Despite the current fiscal constraints, these services continue to expand. Since 1968, the number of nursing care beds in New York City has remained unchanged at 38,000. Domiciliary care beds have increased by several thousand to 15,202, and interestingly have vacancies! The home care alternative has contributed to vacancies in domiciliary care and health related care beds.

Home-delivered, "meals on wheels" programs have slowly expanded. Expenditures of $60 million nationally for home delivered meals funded by Title IIIc of the Older Americans Act are anticipated in FY 1982. These programs have been sponsored by family agencies, Jewish community centers and such multi-functional agencies as JASA.

Experimental adult day centers and day hospitals, on a limited scale, have demonstrated the value of comprehensive care for the frail elderly patient living at home. These centers have enabled families to care for elderly dependents by providing relief from the stress of providing constant care.

The Burke Rehabilitation Center in White Plains, New York, the Day Center of the Levindale Hebrew Geriatric Center and Hospital in Baltimore, the Day Centers of the Jewish Home and Hospital, the Metropolitan Geriatric Institute, and the Mosholu-Montefiore Community Center in New York are good examples of this service. These centers provide medical and psychiatric care, physical, occupational and recreational therapy, social work, transportation, meals, and other services. The centers provide therapeutic medically supervised service designed to restore physical or mental capacity after hospital discharge, or as part of a long term care plan. These services are costly. They have been funded by government Medicaid, research and demonstration grants, and philanthropic resources. These services are in their infancy. Because of this medical orientation and funding, they must be organized under appropriate licensed medical aegis or a contractual relationship with a licensed health care provider to assure quality of care and funding.

"Enriched housing" is a term employed to describe the provision of comprehensive care in residential facilities operated by social agencies. These may range from small apartments to hostels to large scale housing for the elderly developments. A "package of care," may include housekeeping, food services, personal care and case management. Funding of "enriched housing" has encompassed a complex stream of government housing subsidies, Medicaid, Medicare, fees for service and philanthropic contributions.

Family agencies have long been providers of home services for the support of families, children, and the aged. With the growing number of the very old, consideration should be given to strengthening home services. The decision to engage in the expansion of direct provision of this care requires careful evaluation of needs, capacities, availability of staff, costs, and funding. Consideration should be given to becoming a licensed home health agency. The demand and resources for home care services can be expected to increase dramatically in this next decade.

The Health Care Financing Administration has continued to communicate its interest in funding demonstration grants for "channeling" and comprehensive prepaid services under Medicare and Medicaid

Waivers.

Case management can overcome the fragmentation in provision of care for the impaired elderly. It has been demonstrated to be effective.

An Overview

The vast increase in the elderly population over 75 will continue and require a major reorientation of our priorities in American society and within the Jewish community. Throughout the United States serious initiatives within the community during this past decade have immensely strengthened our capacity to respond to the needs of the elderly. The challenge ahead will be greater.

The problems of the elderly are so manifold, so universal, that no single agency can encompass all of the required services. Within the Jewish community this is equally true. Comprehensive services require close coordination with the health agencies, community centers, and other institutions. Because the major funding resources and legal entitlement to home care service originate in the health system in Medicare and Medicaid and must be prescribed by a physician, the social service agencies will be required to reorganize their services in order to become direct providers. Home Health Care and Mental Health Care Services must be provided by licensed health care agencies. Alternatively, the social agency may become a subcontractor of a hospital or skilled nursing home. A notable recent trend has been the engagement of homes for the aged in the provision of long-term home care and day treatment services.

It is possible that the excessive costs of the health system will ultimately shift the provision of home care to social agencies. This has already occurred in New York City in the organization of the Home Attendant Program.

The Future

Despite the continuing national conflict over the allocation of our resources, public opinion continues to support the Social Security and health insurance system for older Americans. The prospects for the last decades of the twentieth century are hopeful. Most Americans will live longer, and so will elderly Jews. There will be a continued improvement in the economic, social well-being and educational levels of all Americans, elderly and, so too, the Jewish elderly.

The gains in life expectancy will be accompanied by a great increase in dependency at the end of the life span at 75, 85 and 95! Within the Jewish community, the aged will require more attention than ever. Our communal services—all of them—will need reorientation toward the aged. Additional resources will need to be allocated to care for older people at home. We need to educate the Jewish community to the prospects of the coming of age. Jewish communal agencies will, I am certain, continue to fulfill their responsibility for the aged, for life itself, as they have in the past.