Community Care for an Aging Society: Issues, Policies, and Services

Carole B. Cox, PhD
Springer Series on Lifestyles and Issues in Aging

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Carole B. Cox, PhD, is Professor at the Graduate School of Social Service, Fordham University. Her gerontological interests and research include the areas of ethnicity and aging, caregiving, and service utilization by older persons and their families. Her research also includes international comparisons of social policy, particularly in the area of community care. Stemming from her work with custodial grandparents, she has written extensively on the issues affecting them and the policies and services that they need in order to carry out their roles. Dr. Cox is the author of numerous articles and book chapters dealing with many aspects of aging. Her previous books include Home Care: An International Perspective (coauthor, Abraham Monk), The Frail Elderly: Problems, Needs, and Community Responses, Ethnicity and Social Work Practice (coauthor, Paul Ephross), and Empowering Grandparents Raising Grandchildren: A Training Manual for Group Leaders. She is also editor of To Grandmother’s House We Go and Stay: Perspectives on Custodial Grandparents. Dr. Cox is a Fellow of the Gerontological Society of America.
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As the new century unfolds, it promises to be composed of a new population. In the next 30 years the number of older adults is expected to double, imposing new challenges and demands on society. With continued improvements in medical care and knowledge of the multitude of factors contributing to a long life, this population of older persons will be healthier and less impaired than earlier cohorts. However, the sheer expansion of the older population and their greater longevity suggests that at any one time there will be significant numbers in need of some care in order to continue living in the community.

Older persons requiring care are often at risk of not having their needs appropriately met when living in the community. Dependency can conflict with an individual’s rights of autonomy and self-determination when the types and provision of assistance desired are not available. Families, who provide the majority of assistance, may find themselves unable to meet the needs of their older relatives when support services are unavailable or inaccessible. Consequently, with limited options, seniors needing assistance may find it available only in an institutional setting.

Our present care system continues to maintain a bias toward institutionalization for persons having difficulties functioning on their own. At the same time, most older persons are anxious to remain in the community and in their own homes as long as possible. This overriding interest, concomitant with the immense costs that nursing homes make on public funds, has stimulated interest in community care services as alternatives to institutions. Consequently, both humanitarian and economic forces are working together to make community care a reality for older Americans.

Policies and services are beginning to focus on the community rather than institutions as the primary axis for care. Attention is being given to the needs of older persons and the many options that can help them to remain in the community. Policies and programs at both the federal and local levels, often with the involvement of private foundations and initiatives, are developing and being implemented throughout the
country. As these continue to expand, they may serve as important models for the further development of community care in the 21st century.

This book begins by examining the many factors contributing to care needs among older persons, as well as the ways in which impairments are defined and responded to both by the individual and society. Policies and the services enacting them that are essential for enabling older persons to continue to live in the community are addressed in depth. The book describes many of the community care innovations that are in their beginning stages, but which hold the promise of making significant contributions to the well-being and independence of the older population.

Whereas most books on aging tend to focus on either practice or policy issues, this book differs in that both are examined along with their effects on the older population. This offers a greater perspective for understanding needs and the ways in which they are being met. The scope of the book makes it particularly appropriate to students in many disciplines, including gerontology, public policy, social work, sociology, and political science. In addition, the book has practical application for planners and service providers as they focus on designing and implementing policies and programs for older persons.

The needs of the older population and the issues that face us in the 21st century are complex. It is my hope that this book will serve as a springboard for ideas and further discussion on the immense subject of community care. Addressing the challenge now, at the start of the century, is crucial for assuring options for coming generations and ourselves.
Chapter 1

Community Care
for an Aging Society

America is aging rapidly, with both the proportion and the sheer number of persons 65 and older relative to the rest of the population continuing to increase. Data from the 2000 Census indicate that there are 35 million persons in the United States age 65 and over, accounting for almost 13% of the population. By the year 2030, this number is expected to double to 70 million persons, with the population 85 and over growing faster than any other age group.

Although the functional status of older persons has been improving, with fewer persons reporting limitations (Freedman & Martin, 1998; Waidman & Liu, 2000), the increasing size of the older population, advances in health care, and longer life expectancies suggest there will be no decline in the number of persons needing care. In fact, it’s estimated the number of older persons with disabilities will triple between 1985 and 2020 (Manton, Stollard, & Corder, 1998). In addition, there is little evidence of any decrease in the total years that older persons spend disabled (Harper & Forbes, 1998). Consequently, persons may be expected to live many years with a disability and with prolonged needs for assistance.

Providing this care in the most humane and least restrictive environment through a system that offers community options that permit people to remain as independent as possible remains a major social challenge. As the majority of older people desire to remain in their own homes as long as possible and with the costs of institutional care rapidly increasing, new and more expansive systems and models of care are essential. Efforts to develop and implement such models are being carried out by both the public and private sectors throughout the country as communities have begun wrestling with demands of their older citizens. This book examines the many factors that contribute to needs for care as well as the policies and services that are beginning to provide for these needs.
NEEDS FOR CARE

Needs for care among the elderly are primarily associated with physical and functional limitations that affect their ability to care for themselves and increase their dependence on others for assistance. In 2000 just over one quarter, 26.1%, of persons age 65–74 reported a limitation caused by a chronic condition, compared with almost half, 45.1%, of those 75 years and over, and almost three fourths (73.6%) of those 80 and over (Administration on Aging, 2002). Needs for assistance also increase dramatically with age with more than a third of persons over 80 requiring some assistance, in comparison to only 8% of persons with disabilities between the ages of 65 and 69.

In addition, levels of functioning and needs for care are not constant throughout the population. Older persons with higher levels of education maintain the highest levels of functioning (Manton, Stallard, & Corder, 1997) while higher proportions of women, Blacks, the old-old, and unmarried persons are classified as disabled (Laditka & Jenkins, 2001). Consequently, those with the least resources are likely to have the greatest needs for assistance.

In order to understand and predict needs of care, it is important to have some knowledge of the progression of impairments and the ways in which they impact on the independence and functioning of older persons. Disability has been described as occurring along a specific progression with difficulties occurring in the following order: walking, bathing, transferring, dressing, toileting, feeding (Dunlop, Hughes, & Manheim, 1997), with women spending more time than men in a disabled state.

According to Nagi (1991) people experience functional limitations when they have an impairment that impedes their ability to perform tasks and obligations associated with their usual roles and activities. The Institute of Medicine (1991) builds on this definition by adding risk factors and quality of life measures to the process. These include biological, social, physical, behavioral, and lifestyle characteristics that affect a person’s ability to cope and function.

Further refinement of this model of disability stresses the role of the interaction between the person and the environment as defining the disability that the person experiences (Brandt & Pope, 1997). If a person with a particular limitation has sufficient supports, the impact of a specific disability will not necessarily limit functioning. Consequently, disability is a relative rather than constant concept, since interventions could be used to restore or improve the functioning of an older person.
PHYSICAL CONDITIONS AND IMPAIRMENT

According to the 1990 Survey of Incomes and Program Participation (SIPP), a national survey of the noninstitutionalized population, the major causes of disability for persons 65 and over are arthritis, coronary heart disease, back problems, respiratory conditions, visual impairments, stiffness, and stroke. The major conditions causing persons in the community to require care and assistance are arthritis, coronary heart disease, visual impairments, stroke, and respiratory conditions. In addition, vision and hearing loss exacerbate other impairments (Kempen, Verbrugge, Merrill, & Ormel, 1998; Wallhagen, Strawbridge, Shema, Kurata, & Kaplan, 2001) and the ability to carry out activities of daily living.

For older persons, arthritis and visual impairments, nonfatal conditions, have as much of an impact on limiting activities as fatal conditions such as heart disease, pulmonary disease, and cancer (Verbrugge & Patrick, 1995). The importance of arthritis as a factor in functional limitation is related to its severity (Guccione, Felson, & Anderson, 1990). Persons disabled as a result of the disease are more disabled than others but, at the same time, these disabilities are less severe, have shorter durations, and develop more gradually than disabilities due to other conditions (Verbrugge & Juarez, 2001). Researchers (Boult, Altmann, Gilbertson, Yu, & Kane, 1996) also believe, however, that if the prevalence of arthritis could be reduced by 1% every 2 years, there would be a much greater reduction in functional limitation between the years 2000 and 2049 than would occur by decreasing any other condition by the same amount.

Falls are one of the major causes of disability among older persons. Multiple factors leading to falls include lower extremity weakness, poor grip strength, balance disorders, functional and cognitive impairment, multiple medications, and environmental hazards. Falls have both physical and social consequences, as they can not only cause injury but may also lead to fears and anxiety that can result in loss of self-confidence and in self-imposed limitations on personal functioning. The consequences associated with falling and the fear of falling can contribute significantly to functional decline, and consequently, to increased needs for care.

MENTAL HEALTH

Cognitive Impairment

Cognitive impairment is also a major factor contributing to dependence and care needs among older persons. Although there are several causes
of cognitive impairment, Alzheimer’s disease (AD) is the most common among older persons. The disease entails a progressive deterioration in the brain that severely jeopardizes a person’s ability for self-care. Although it can afflict younger persons, it is most prevalent in the older population, with persons over 85 years of age more than twice as likely to be afflicted.

The course of the disease generally begins with memory loss and some difficulty in performing usual activities such as balancing a checkbook, shopping, or driving. As the illness progresses and the connections between nerve cells in the brain deteriorate, persons lose the abilities to perform most tasks associated with independent functioning, such as dressing, bathing, and feeding oneself, while in the final stage they become bedridden and totally dependent. Indeed, research has indicated that dementia and cognitive impairment are the strongest contributors to functional dependence among the elderly (Aquero-Torres, Fratiglioni, Guo, Viitanen, von Strauss, & Winblad, 1998).

It is estimated that more than 4 million people have AD, with the prevalence rate doubling every 5 years beyond age 65. Estimates are that approximately 360,000 new cases will occur each year and that this number will increase as the population ages (Brookmeyer, Gray, & Kawas, 1998). The extent of the problem in providing care for this population is vividly underscored by its annual costs, which are estimated to be over $100 billion per year (Meek, McKeithan, & Schumock, 1998). Thus, AD and the loss of functioning that it entails are major contributors to the needs for care presented by an aging population.

**Mental Illness**

Physical impairments are not the only risk factors with regard to impaired functioning among the elderly. Attention must also be paid to the impact of mental health problems, particularly depression, the most prevalent mental illness of the elderly, on the functioning of older adults. According to one estimate, the number of older persons with psychiatric disorders will grow to 13 million persons in the next 3 decades (Jeste et al., 1999).

Data from the Health and Retirement Study (1998) showed depression to be common among older persons, with severe symptoms reported by 15% of those 65 to 69 and by 21% of those 80 to 84, increasing to 34% of persons 85 or older. A study of older persons living in the community found that 19% had 6 or more depressive symptoms and that these were associated with poor self-rated health, disability days,
limitations in physical functioning, perceived poor social support, and the use of psychotropic drugs (Hybels, Blazer, & Pieper, 2001).

Other research shows that depressive symptoms among the elderly are prevalent and associated with morbidity and functional impairment (Lyness, King, Cox, Yoediono, & Caine, 1999). Findings from a survey of physical functioning in over 11,000 patients showed that depression strongly affected the ability of the older patient to carry out the activities of daily living (Wells et al., 1989). The disabling effects of depression on bathing, climbing stairs, dressing, socializing, walking, and working were comparable with those of a serious heart condition and greater than those most of the chronic conditions of angina, arthritis, back problems, coronary artery disease, diabetes, gastrointestinal problems, hypertension, and lung problems. The apathy, indecisiveness, withdrawal, and sense of helplessness associated with depression can be conducive to dependency and impaired functioning, as the symptoms affect the older individual’s motivation and capacity for self-care.

Depressed elderly engage in less physical activity and have fewer social contacts, which may increase their risk for disability (Pennix, Leveille, Ferrucci, van Eijk, & Guralnik, 1999). However, by offering social interactions to depressed elderly and engaging them in social networks, functional declines can be reduced and even the most depressed can be assisted to maintain their basic functional abilities (Hays, Steffens, Flint, Bosworth, & George, 2001). Consequently, efforts that address mental health needs of seniors, particularly with regard to reducing their isolation, can be an important factor in strengthening their functional status.

HEALTH CARE

Being able to function in the community may depend a great deal upon the health services available and accessible to the older person with a disability. Health care for the functionally disabled involves both acute and long-term care services and thus requires medical professionals who are knowledgeable about geriatric care. Persons over the age of 65, though they accounted for only 12% of the total population in the year 2000, made 24.3% of all visits to physician offices, according to the National Center for Health Statistics, with almost half of these visits being made to primary care physicians.

Given that the prevalence of chronic illness increases with age, these primary care physicians play a pivotal role in the course of care of these older adults. Unlike acute care, the needs of those with chronic
conditions resulting in physical limitations often require the physician to be cognizant of the array of long-term care services to meet these patients’ needs. Being able to assess needs and limitations and being knowledgeable about the types of services that can assist the person in the community, ranging from home care to day care and respite care for families is essential if care needs are to be effectively met.

Medicare, the primary health care health care provider for those over 65, is not focused on chronic care needs. According to the National Chronic Care Consortium (2003), elderly with two or more chronic conditions account for 95% of Medicare costs, but current payment plans are not conducive to physicians serving these needs. In addition, there is a paucity of physicians trained in geriatric care. Health problems can be overlooked, dismissed as a normal part of aging, or misdiagnosed, with the consequence being that interventions that could improve these conditions and subsequent functioning are not offered. In addition, the complexity of care required by the frail older adult and the efforts needed to make appropriate assessments, restore functioning, and even arrange for and coordinate services demand extensive planning and time. To date, Medicare does not reimburse physicians for the time it takes to provide the types of care management that these persons require.

The demands that those with chronic disabilities are placing on the health care system are not going unrecognized. The Geriatric Care Act of 2003 would authorize Medicare coverage of assessment and care coordination of those with serious and disabling chronic conditions. The proposed legislation would also expand medical residency training in geriatrics so as to engage and develop a more knowledgeable and skilled cadre of physicians to serve this population. The act underscores the important role played by families of the frail as it includes support for both patient and family education and counseling as well as the development of self-management services.

MENTAL HEALTH CARE

With mental health playing such a key role in the functioning of older adults, detection and treatment of the illnesses and disorders that can impede functioning should be an urgent concern. Unfortunately, older people are the most at risk of not receiving mental health care, and the least likely to visit mental health professionals.

Less than 3% of persons over the age of 65 receive outpatient mental health treatment from a specialist, a rate that is much lower than any
other age group (Olfson & Pincus, 1996). When persons do go for care, they tend to seek help from their primary care providers who may or may not detect their problems. A vivid illustration of the impact of inadequate treatment is found in a study of suicide among older adults (Conwell, 1994). Twenty percent had visited a physician the day of their suicide, 40% within the week, and 70% within 1 month of the suicide.

Feelings of stigma associated with mental health problems, issues associated with access, financing and insurance, feelings of denial, and an absence of trained mental health professionals are among the reasons for the under-treatment of these conditions. In addition, although available, appropriate treatments and interventions that can relieve symptoms and improve functioning are not being fully implemented in clinical practice (Bartels & Smyer, 2002).

A shortage of trained professionals and limited payments and reimbursement for community mental health care are two of the major impediments to service. With Medicare, patients are required to pay 50% of the costs of outpatient mental health visits, in comparison with 20% of other physician visits. With limited prescription drug coverage by Medicare and many other insurance plans, pharmacological treatments for depression and other mental illness are often inaccessible to many older persons.

**RISKS FOR IMPAIRMENT AND CARE**

As we enter the 21st century, major advances in health care and in our understanding of the nature and progress of disabilities can help to prevent or delay functional dependency among the older population. Moreover, new technologies, methods of rehabilitation, and services, coupled with alterations in a person’s environment, can negate many of the consequences associated with disability and limited functioning and thus increase the potential of preventing dependency. Equally important is the role that psychosocial resources—including one’s own sense of mastery and control, and personal relationships—have in improving functioning and helping persons to cope better with chronic conditions and disabilities.

Findings from a large-scale longitudinal study of aging indicate that risks for functional decline, even among older adults with chronic conditions, can be influenced by physical exercise, social support, self-efficacy beliefs, and feelings of psychological well-being (Seeman & Chen, 2002). Having emotional support may be protective of decline as it enables
persons to better deal with the stress that can accompany functional limitations and chronic conditions.

One of the main precursors of dependency in older adults is a sedentary lifestyle. Decreased physical activity leads to muscle weakness and bone fragility, and older persons generally move less frequently than younger persons. In a comprehensive review of the concept of frailty in older adults, Bortz (2002) describes it as a state of muscular weakness with other secondary losses in function and structure that are usually initiated by decreased levels of physical activity. Lifestyle interventions, including changes in nutrition and physical activity, may play major roles in preventing disability and functional loss among older persons.

Maintaining muscle strength is fundamental to performance of many of the tasks of daily living, such as getting out of bed, walking, or rising from a chair. In addition, weakness in the lower body and impaired strength increase the risk of falling and of being injured as a result of a fall (Work, 1989). Although the evidence is still inconclusive, there is some which suggests that exercise and weight-bearing exercises can be important factors in reducing falls among the elderly and thus in reducing the risk of serious disability.

Sedentary lifestyles also lead to a more rapid decrease in leg muscles. Exercise programs continued over time can counteract this decrease by increasing muscle mass and bone density. Intervention studies using exercise programs for frail older adults demonstrate significant improvement in the subjects’ balance, muscle strength, walking function, and self-assessed functional ability (Worm et al., 2001). Of particular importance are exercises that increase strength by increasing muscle mass. Even the oldest of the old, those 85 and over, have been found to significantly increase their strength through weight lifting exercises (Shephard, 1987). According to Shephard, participation by the elderly in three 1-hour exercise classes per week may reduce health care costs of acute and chronic treatment, mental health treatment, and extended residential care by more than $600 per year for each older person.

Health education activities, as they focus on functioning and positive health practices, can counteract belief systems and attitudes viewing dependency and frailty as unavoidable risks, even for those with impairments. Studies show that older persons who lead healthy lifestyles and engage in activities that promote their health are functionally more healthy than their peers (Duffy & MacDonald, 1990). Moreover, the same data found that the oldest and most impaired group, those 85 and older, had the highest exercise levels, providing further support that functioning is not necessarily equated with impairment.
The prevention of mental impairments leading to dependency is potentially even more complex than that associated with the prevention of physical ones. At the same time, as many spheres of the older individuals' lives may contribute to their mental health, there are innumerable areas for intervention. Socialization programs, environmental supports, therapy, and counseling are examples of interventions that can assist persons dealing with both physical and emotional loss and transitions. The availability of these programs and services, tailored to the needs of specific groups, can be significant in helping persons adjust to and cope with the many transitions incumbent in aging.

THEORETICAL PERSPECTIVES ON IMPAIRMENT AND CARE

This review of the factors conducive to functional impairment and consequent needs for care among older persons underscores the interactions and complexity of factors that affect the well-being and status of the older population. Many theories of social gerontology can assist in unraveling this complexity by providing a conceptual framework linking these factors together in a coherent manner. These theories can also indicate those who are most vulnerable to dependency as well as providing a framework for the development of specific interventions.

Continuity theory is particularly pertinent to the experience of older adults at risk of functional declines. This theory maintains that older persons seek to continue in their usual roles and lifestyles throughout the aging process. Individuals have a coherent structure that persists over time but allows for a variety of changes to occur (Atchley, 1989).

Two fundamental aspects of the theory are internal and external continuity. Internal continuity refers to the persistence of ideas, personality, preferences, and temperament. People seek to maintain a sense of internal continuity because it offers a sense of competence, control, and self-esteem.

External continuity refers to the maintenance of social roles, role relationships, and activities. External continuity is important to the maintenance of strong social supports, and perhaps more significantly, to the maintenance of a strong self-concept. Internal continuity appears to remain constant over time, in that persons tend to interact with those who support their sense of self and who maintain their sameness. A desire for external continuity also appears to be the norm in that persons continue to use established skills, perform accustomed activities, and interact within the same relationships.
However, both mental and physical impairments can pose obstacles to continuity. The older person whose memory is no longer intact will be thwarted in his or her attempt to maintain internal continuity. The person with physical impairments that make the performance of traditional skills impossible may find external continuity jeopardized. In both cases, reductions in social support systems can further threaten continuity. Unfortunately, such transitions in these systems frequently occur simultaneously with the older person’s impairments, so that discontinuity develops. It is with this discontinuity that the older individual becomes susceptible to a decline in functioning.

According to symbolic interaction theory, identity is developed and maintained through interactions and reinforcement with others in society (Mead, 1934). Reference groups, those with whom the individual identifies, and significant others, those who are influential in the individual’s life, are key actors in the development of self. Through interactions with these sets, proper roles and expected behaviors are learned and self-concept is developed.

As applied to older persons with impaired functioning, they are susceptible to developing a negative self-concept due to the nature of their interactions with others. As others perceive and treat older persons as dependent, through actions and behaviors that reinforce their limitations, they become increasingly susceptible to defining themselves as frail and in need of care. Accordingly, they may begin to further limit their activities and question their own self-sufficiency. Dependency is therefore socially construed as it becomes a part of the individual’s self identity.

“Learned helplessness” builds upon symbolic interaction theory and can give further insight into the onset of dependency. According to the concept, helplessness develops as the impaired begin to accept the loss of control over their own lives and their dependency. Individuals become increasingly passive, dependent, and helpless, and begin to lose confidence in their ability to function (Seligman, 1975). Unfortunately, others, as they offer assistance, only serve to exacerbate this negative self-concept. Rather than focusing on strengths, they tend to focus on the disability with the result being that the disabled elderly perceive themselves as helpless and dependent on others.

The interactionist perspective is further delineated in the theory of social breakdown/reconstruction (Bengtson, 1976). The theory delineates many factors in the environment that can act to threaten and destroy the older person’s sense of competence. As abilities become less acute, the impaired individual is vulnerable to being labeled dependent with the identity reinforced by those offering care and assistance.
The outcome is that as care is accepted, the older person is vulnerable to becoming increasingly dependent.

Using a reconstructionist model, Bengtson proposes that the vicious circle leading to dependency can be broken. By having those offering care and support reinforcing the strengths and coping abilities of the older person, confidence can be rebuilt and breakdown halted or reversed. In this way dependency does not become a part of the identity and functioning may be at least partially restored.

Ecological models which focus on persons in the environment are particularly appropriate to the functioning and care requirement of older adults, as they can help identify those areas where supports that can enhance functioning are needed. Lawton and Nahemow’s (1973) model of environmental press is based on a balance point between environmental demands and individual capabilities, with optimal functioning occurring when the older person is able to satisfy behavioral needs and maintain psychological well-being. If the relationship changes so that the environmental pressures become too severe or the person’s competency to deal with the environment is weakened, interventions that modify or alter either the setting or the capability of the person are required. In addition, the individual’s own appraisal of the situation is an important factor in determining press, as it affects whether or not they believe a disability exists or what action to take to moderate it (Lawton, 1998).

These theories suggest that individual needs for care, in addition to stemming from functional impairments, can be affected by social-psychological factors and that disability or impairment is not necessarily sufficient as a predictor. A devalued self-image associated with a sense of helplessness that is reinforced by others can contribute to the development or enhancement of dependency and hence the needs for care. In addition, as the environment fails to respond to the abilities of the older person, persons become increasingly vulnerable.

In addition to theories that focus on individual responses to aging and impairment, an important framework for examining the functioning and status of older persons in a society is the political economy perspective. This perspective views old age and the problems associated with aging as socially constructed and resulting from the unequal distribution of resources. The central focus is on analyzing the structural conditions and socioeconomic factors that create inequality in old age and affect the policy interventions that occur in a capitalist society.

Using a political economy perspective, the challenge is not to see how persons interpret their private troubles but to see how these private troubles become public issues (Estes, Gerard, Zones, & Swan, 1984).
The perspective helps to explain the experience of old age, the patterns of inequality among older people, and how public policy may ameliorate or exacerbate such inequalities (Quadagno & Reid, 1999).

Consequently, the political economy framework expands our understanding of the ways in which society offers resources and care to older adults. By examining the impact that class divisions, gender, and discrimination have had on persons throughout their lives and the ways in which services have been offered or available to them, a greater knowledge of the process of current provisions to older persons can be obtained. The perspective highlights the inequalities in society, their impact on the older population, and the ways in which social policy can continue to perpetuate such inequalities.

CONSEQUENCES OF IMPAIRMENT

Functional impairment can limit a person’s autonomy because it commonly involves restrictions in the individual’s capacity for decision making. Older adults who require assistance either from their family or from agencies frequently find that the number of choices regarding their care is limited as a consequence of their impairments. In many instances, dependency upon others means giving these persons the power of decision making in their lives.

Losing the autonomy of action and the ability to function independently is often associated with forfeiting the capacity for self-actualization. Dependency can connote that the person no longer has the ability to act with any judgment. Consequently, by requiring care, a person can be placed at risk of having decision-making powers revoked or restricted due to perceived incompetence. Obviously, these perceptions can further threaten the individual’s self concept and eventual ability to remain independent.

As dependency can convey vulnerability, it can threaten a person’s right to autonomy and self-determination. As policies, families, friends, and services wrestle with meeting the care needs of older persons, they are often at risk of infringing on their basic political and social rights. Planning and designing appropriate services and interventions that address their needs in the community without creating further dependency or inequality is therefore an expansive task that necessitates sensitivity and commitment.

The consequences of requiring care are not restricted to older persons themselves, as it is families that continue to provide the majority of this assistance. The challenges and burdens that these caregivers
encounter have been well documented. Thus, although relatives are the foundation for community care, this is not without consequence to their own well-being. In addition, the continued availability of these family caregivers is debatable. Shifts in the demographics of the population mean fewer adult children are available to care for the burgeoning number of elderly, while spousal caregivers are likely to be elderly themselves, affecting the extent and types of care that they can provide.

Finally, it is important to remember that growing old does not necessitate disability and frailty, and healthy aging is not an oxymoron. The majority of the elderly reside in the community and function with little restriction on their activities, and even when restricted, are able to maintain their independence. At the same time, the rapid growth of the older population means there will be increasing numbers of persons with chronic illness and functional limitations who will require some assistance in order to live as they would desire. The continuing challenge is to ensure that older persons have options with regard to resources and services that can enable them to remain as autonomous as possible, in a supportive environment with a high quality of life.

SUMMARY

This book addresses some of the major issues confronting the frail elderly. As this introduction indicates, frailty cannot be narrowly defined or predicted. Many factors, physical, mental, and social can result in frailty and thus appropriate interventions must be made in accordance with this diversity of causes. The majority of the those with impairments reside in the community and therefore the focus of this book is on the ways in which the community responds to the problems and needs of this population.

Impairment and disability are not going to disappear, nor are the demands and needs of those requiring care and desiring to remain in the community. With the expansion of the elderly population, it becomes increasingly important to understand who is most at risk of frailty, and why. Only with such knowledge can a comprehensive framework of policies and services directed at both prevention and care be designed.

The ramifications of an aging population and of the needs of those with functional limitations affect everyone and defy simple unitary solutions. The issues surrounding such care are broad, involving many spheres of life. In order for responses to be effective they must extend beyond just one field so that they can best encompass the many variables influencing well-being and independence in later life.
This book, as it addresses the issue of frailty among elderly in the community, begins, in chapter 2, with a discussion of the way in which frailty is defined and the complexity of the term itself. Policy provides a necessary framework for meeting the needs of the frail, and as the book describes in chapter 3, these policies are being designed at many levels, federal, state, and local, yet their effectiveness remains questionable. The community responds to the needs of the impaired elderly through services offered through both the public and private sectors. Chapter 4 describes the major services that can have an impact on the lives of these elderly. Housing for older persons with impairments remains an overriding concern, and in chapter 5 the various available options, including adaptations in the home, are described.

Families provide the bulwark of assistance to these elderly. Chapter 6 presents theoretical perspectives for understanding the involvement of these family caregivers while also discussing the extent of family involvement, its effects on the older person, and its effects on the caregiver. As ethnicity and minority group membership in particular can influence both the development and perception of frailty, as well as the way in which the family responds to it, chapter 7 is devoted to an elaboration of this subject.

Much innovation is occurring throughout this country with regard to the care of older persons in the community. Chapter 8 describes some of these innovations as they may provide important models for programs and services. Chapter 9 is an attempt to summarize and draw conclusions about the needs of this population and the effectiveness of current responses, and suggests recommendations for change.

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