Elaine Theresa Jurkowski, MSW, PhD, is an associate professor and graduate program director at the School of Social Work, Southern Illinois University Carbondale (SIUC). Dr. Jurkowski also coordinates the Certificate in Gerontology through the College of Education and Human Services at SIUC. Dr. Jurkowski’s professional background includes both social work (BSW, MSW) and public health (PhD). Her work in the policy arena began during her undergraduate degree program in social work and has continued throughout her career. Dr. Jurkowski has spent most of her career writing about access to care issues for older adults and people with disabilities. She has been effective in shaping policy and program efforts in several countries in addition to the United States, including Canada, India, and Niger, West Africa.
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Preface

Realities and Visions
Looking around oneself either at the grocery store, at a shopping mall, or in the workplace, a common thread may be seen—a graying population. The first of the baby boom cohort turned 60 in 2006, and by 2030, it is anticipated that 20% or more of the adult population in the United States will be 65 years of age or older. Consequently, social work, public health, human services, and allied health professionals will be at the forefront of service delivery and policy development. Thus, resources and tools to adequately prepare these individuals for the journey ahead, to meet this changing society, will be vital and critical.

In response to this need, this text, Policy and Program Planning for Older Adults: Realities and Visions, has been developed. This textbook offers some innovative features. Essentially, the book will take a public health/population health approach to the development of programs and services for older adults. The book attempts to build students’ understanding of policy development through a critical analysis and review of policy frameworks, and the policy implementation process. Once the student understands how policies are formulated and implemented, a second innovation will include the development of skills to shape programs and the implementation of policies. Skills to shape policies and programs such as media advocacy, coalition building, and health promotion frameworks will also be addressed within the text. Last, community-based programs and services are addressed within the context of text. Existing policy texts neglect to triangulate skills, policies, and programs for the reader. Existing texts also neglect to blend a social welfare and public health approach into their conceptual designs.

Layout of this Book
This book has been developed with the notion that it will provide the reader with an overview of dimensions impacting policy development,
apprise the reader of current mandated policies in the United States that will affect older adults, identify and present tools that are helpful in building both policy and programs for older adults, and showcase programs and services for older adults. Each chapter provides the reader with Web sites that can be used for additional reference information. Each chapter also presents some notion of the realities facing older adults within each topical area, and a summary chapter outlines both realities of today and visions for the future. It is the author’s hope that this resource can be valuable for advocates working within the field of aging as they develop programs and policies for our next generation.

Part I of this book lays out a background as to the current and future demographic trends of older adults and makes the case for the reader that there are a variety of philosophical, political, economic, and social factors that affect public policy development. The chapters help the reader explore a range of perspectives that define, shape, and impact the development and implementation of public policy. This section is also intended to prepare the reader to be able to critically analyze public policies related to aging.

Chapter 1 provides a demographic profile of the aging population (60+ years) currently, and reviews how these demographics have changed from 1900 until the present time. Demographics are also reviewed from the perspectives of specific health outcomes, gender differences, ethnic composition, and rural/urban dimensions. The chapter concludes by looking at how these specific demographic changes will shape challenges for the future and gaps to be addressed through policy and program developments.

The second chapter takes the reader through a historical review of policy, economic, political, and social changes that have occurred both on the American and global fronts. It reviews such dimensions within 10-year increments, highlighting major innovations or developments from 1900 to 2005. The chapter concludes by challenging the reader to consider factors that have led to innovations in science and technology as opposed to aging-related policies and lays the groundwork to begin to explore philosophical paradigms that impact policy development.

Chapter 3 provides an overview of different philosophical paradigms that impact the development of policy proposals and eventually drafted or legislative bills. The chapter also explores various factors and policy frameworks that impact the implementation of aging policy. Philosophical paradigms include “blaming the victim,” “elitism,” “social welfare as a right,” “econometric perspectives,” “cause versus function,” and “window of opportunity,” to name a few. These philosophical frameworks help the reader understand the development of aging-related policies and programs, while the policy frameworks help the reader understand the
implementation process related to aging policy. Implementation strategies will include frameworks such as “street-level bureaucrats,” “incrementalism,” “rationalism,” and “window of opportunity.” An important perspective of this chapter is that the reader is exposed to the view that a range of perspectives ranging from extreme liberal to conservative impact the development and implementation of public policy.

The fourth chapter of the book, and the last in Part I, lays out a variety of tools and government documents available and how these are used to provide evidence and rationale for public policy development and analysis. Sources include “Congressional Universe,” “Thomas,” Government Printing Office (GPO) documents, Government Accounting Office (GAO) documents, and various databases available through the national database sources. This chapter also makes the linkage between using data and evidence to support policy and program development decisions. Some exercises are provided at the conclusion of the chapter to help the reader understand and utilize these sources.

Part II of this text will provide an overview to major federal policies and programs that impact older adults and people with disabilities. Some historical developments leading up to the actual development and implementation of the policies are also examined. Policies include Social Security, Medicare, the Older Americans Act, the Americans with Disabilities Act, the Community Mental Health Centers Act, and Freedom Initiative.

Chapter 5 provides a backdrop to our current Social Security Program, provides an overview to some models for Social Security programs in Europe and Canada, and explores the genesis of the Social Security program in the United States. The contents of the original Social Security Act will be explored and compared to the current-day titles and programs mandated through the current Social Security Act. Chapter 6 reviews the history of Medicare and reviews some of the changes in Medicare legislation over time. It also provides an overview of the current services available through Medicare Parts A, B, C, and D.

The Older Americans Act has seen a growth of programs, legislative resources, and a series of amendments since its inception into law in 1965. This chapter reviews some of the history leading up to the signing, the original components of the act, amendments that have occurred over time, and, finally, the most recent amendments of 2006, which will serve as a guidepost until 2011.

Chapter 8 provides an overview to the Americans with Disabilities Act and examines how this landmark piece of legislation impacts the lives of older adults. Mobility impairments and other impairments associated with disability and chronic conditions have posed major barriers and challenges to people as they age and develop mobility or sensory limitations. Within
the area of mobility and sensory deficits and challenges, older adults have greatly benefited from the work and accomplishment of the disability and independent living movements.

Chapter 9, the last in this part on legislative initiatives that impact older adults, reviews mental health legislation and its impacts for older adults living within the community. It also explores President Bush’s Freedom Commission Initiative and explores how this legislation affects older adults’ lives in the United States.

Part III provides some tools for the reader to use to be more adequately equipped to prepare program initiatives that flow from policy appropriations. The tools also are designed to prepare the practitioner or reader with some skills to more effectively advocate for policy change. This section helps bridge some of the skills and tools used both within the disciplines of social work and public health and begins to expand the boundaries of public policy development.

Chapter 10 addresses health behavior models and lays out the premise that understanding and programming with some concept of health behavior in mind will strengthen community-based programs and improve the return on investment in these programs. Health behavior models addressed within this chapter will include four specific models, including the “health belief model,” “stages of change,” and “theories of reasoned action.” An overview of these models and their components will be presented and reviewed. These will then be examined relative to aging policies and the implementation of specific programs. The chapter concludes with making a case for the importance of using health behavior models in the development of aging programs and provides some “best practice” examples.

Chapter 11 provides an innovative tool for policy advocates, which is the use of media and advocacy strategies for change. This chapter provides an overview of the social marketing process and media/advocacy strategies inherent in the process of developing advocacy campaigns for creating public awareness. A variety of specific constituent groups are addressed, and media strategies are presented. Strategies include the use of preparing sound bites, developing fact sheets, letter writing campaigns, use of the Internet, infomercials, and “trinket techniques” (t-shirts, bumper stickers, visors, etc.).

The focus of tools presented in chapter 12 is on coalitions and coalition building. This chapter provides an overview of coalitions, and their development and use as a technique for policy development or program implementation.

Chapter 13 outlines and reviews tools used in the needs assessment process. This chapter outlines the use of needs assessment tools and how either one, or all five strategies discussed in this chapter are used in the
development of community, agency, state, or national priorities. Strategies include community forums, social indicators, key stakeholders, service statistics, and surveys.

The third part of this text concludes with chapter 14, which attempts to pull together each of the chapters in this section on tools and make the linkage between the first three parts and the last part of this book. This chapter provides the reader with a short overview of how the tools presented are salient in the process of program development and sets the stage for the concluding part of this text.

This last part of the text outlines specific programmatic areas that flow from aging policies, and specific components that flow from federally mandated policies. Each chapter will be written with the same basic outline: an overview of the programs, specific features and strengths of the programs, gaps and areas for development, and challenges for the future. The tools and concepts presented earlier in this text will be integrated and woven throughout each of the chapters in Part IV.

Chapter 15 explores various models of community living and residential options for older adults. Traditional models of long-term care, home- and community-based, will be examined and innovative approaches presented, such as consumer-directed approaches. This chapter examines the current status of the long-term care system, seeks to provide different residential models of care for people as they require community-based settings or settings with supports, and addresses issues that will face the long-term and community-based care settings in the future.

Chapter 16 examines the mental health needs of older adults, addresses the programs and services available to meet this need, and addresses gaps such as counseling, peer support, and resources to meet the needs of dual diagnosis such as substance abuse and mental health. The prevalence of various mental health disorders is presented in this chapter, and the chapter concludes with an exploration of model programs around the United States to address the mental health needs of older adults.

Chapter 17 explores health care needs and services for older adults. This chapter will examine the traditional programs offered for preventive, acute, and chronic care within the Medicare program. Gaps such as oral health care, screening, and assessment will also be examined.

An issue that has been on the rise, that of grandparents raising grandchildren, is explored in Chapter 18. This chapter examines some of the legislation that affects grandparents raising grandchildren, such as child welfare components. It also addresses the unique dilemmas grandparents raising grandchildren face when straddling aging and child welfare policies. This chapter also provides an overview of the current status of grandparents raising grandchildren, as well as some background on the literature, and it provides an awareness of issues that grandparents face
as primary caregivers. A literature review examines some of the current issues and services needed. Resources and services designed to meet the needs of grandparents raising grandchildren are discussed, and programmatic responses identified through the national resources. Lastly, some best practice interventions are outlined for review.

Elder abuse is addressed and gaps in services and public policy are presented in Chapter 19. The incidence and prevalence of elder abuse is probably largely underreported. While efforts are being made to understand the magnitude of the problem, limited resources hamper progress. The Older Americans Act has some resources in place to deal with the education of providers and screening/detection of individuals who have been at risk of abuse; however, Adult Protective Services plays a key role also in this intervention process. The role of one’s cultural beliefs and help-seeking behavior also plays a significant role. Challenges in uncovering this silent epidemic face the health care provider, programs, and services.

Legal issues, including those related to power of attorney, enduring power of attorney, end-of-life care issues, are examined in Chapter 20. It also presents dilemmas in public policy development relative to how these are implemented. In addition, legal services provided to older adults as a result of the Older Americans Act are explored, and challenges within the realm of legal issues outlined.

The last chapter concludes by laying out realities, proposing visions for the future, and summarizing a top 10 list of challenges for the future, listed here.

1. Designing paradigms to meet the demographic and social needs of our graying population through evidence-based approaches.
2. Social Security—boom or bust?
3. Medicare: Will there be a pot at the end of the rainbow for preventative services?
4. Understanding health behavior and planning with this understanding in mind
5. Using the media, advocacy, and coalitions for social change
6. Home- and community-based care
7. Mental health programs, services, and issues
8. Health programs, services, and issues
9. Long-term care
10. Diversity and special populations

This text also offers various unique features, which include some of the following:

- The book is presented in four parts, addresses philosophical paradigms underlying policy making, addresses current policies
impacting older adults, describes tools and strategies for policy making and program planning, and presents programs and services to address the needs of older adults.

- The book addresses some unique areas such as evidence-based policy development, the media, and coalition building.
- The book presents materials on the new Older Americans Act reauthorization.

In addition, this book addresses specific strategies and tools that can be useful in the development of renewed social policy for older adults or people with disabilities and equips the reader with tools and strategies to impact public health or health policies and programs. The reader is apprised of current legislative efforts that impact older adults in practice settings, or that impact program development. It also provides a conceptual or philosophical framework that guides the development of social policy. Tools, strategies, and resources that shape social policy efforts are also addressed, followed by programs and services currently in place. Since the text is sole authored, a linkage between chapters is possible, which lends itself to continuity throughout the text.

A graying society is a reality—thus we can be prepared to plan, or we can plan to fail. Planning promotes engagement, thus rendering a healthy community and a foundation for our generations to come.

Elaine Theresa Jurkowski

Carbondale, Illinois
In the next 20 years the number of adults in the United States over the age of 65 is expected to double. This dramatic increase in the numbers of aging individuals has been referred to as “the demographic imperative.” As a result of changes in medical care, health care policy, and technology, older adults are living longer than ever before, and their needs are changing. Today adults over the age of 65 represent 12.3% of the US population. By 2030 that percentage will increase to 20%, or 71.5 million people. The percentage of older minorities in the population will also increase from 16% in 2007 to 25% in 2030. By now it is recognized that this shift in the age of the United States population will seriously strain the medical, health care, and social services systems.

With the oldest members of the baby boom generation reaching the age of 65 in 4 years, the number of older adults in the U.S. population will present a profound challenge. The fields of medicine, social work, nursing, public health, gerontology, and others will have the opportunity to support older adults—those aging well and those who will need increased social services, medical, and long-term care—in order to help them maintain the highest level of quality of life.

Controversies are already emerging throughout our society about what the elderly should receive, what care and when, and who should pick up the bill and for how long. Aging-related issues are being debated in the halls of Congress, in the media, and in the privacy of our own homes. Whether we work with older adults or not, policy issues related to their needs are rampant and will have an intergenerational impact.

The emerging demographic, economic, and social realities have upset the foundation of existing paradigms regarding older adults. Can we afford to be our brother’s keeper? Do older adults really need us like they did 50 years ago? And, considering the population explosion within this cohort, we are even asking how can older adults contribute to society?
Complicating the situation is that, unfortunately, we appear to be in an era of retraction rather than expansion of our safety net and, therefore, we may not meet this demographic imperative’s demand. Given the perception of scarcity, even the 2005 White House Conference on Aging was focused on the importance of “individual responsibility” rather than “entitlements.” The whole question of aged-based policy is controversial. Are people entitled to something simply because of their age? How do we translate policy into programs and vice versa to make sure we are attending to the diversity of not only the needs of older adults but also those who care for them?

Clearly, alternative strategies are needed to improve comprehensiveness and quality of care in view of the projected growth in the millions of Americans expected to have multiple chronic illnesses, the huge increase expected in the numbers of older adults as the baby boom generation ages, and the economic, demographic, political, and systemic pressures for services amidst greater challenges and declining resources.

My experience as a John Heinz Senate Fellow, when I took a sabbatical from my practitioner role to better understand and influence policy, was invaluable. Learning about policy development from the ground up gave me a better understanding of how to effectively address seemingly insurmountable issues by gathering evidence and forging coalitions. There is no question that government can move slowly at times; however, Senator Clinton and her staff taught me that the system can still serve its citizens’ needs. I observed and believe that if people can frame their issues clearly and advocate for them before Congress, they can really make a difference by influencing the legislative agenda and future policy. Although some of the political and partisan truths that surface throughout the legislative process may be daunting, the ability to have a real effect on the course of the nation’s older Americans is indeed possible. These effects may be incremental and slow in coming, but the immediacy and relevancy of the political and policy process is an awe-inspiring one.

We in the field of aging must involve ourselves in today’s public debate and political struggles not only for the benefit of older adults but also for those who will be asked to support them. This book, *Policy and Program Planning for Older Adults: Realities and Visions*, provides us with a structured, comprehensive guide to policy development and planning that will be useful for the experienced practitioner and the neophyte as well. Dr. Elaine Jurkowski presents a realistic portrayal of policy and planning for aging issues. The hands-on case examples demystify the process, making the content accessible and comprehensible. The text is all encompassing and can be used in sections or as a whole. The challenges of an aging
society can be met by engaging in Dr. Jurkowski’s critical analysis and review of policy frameworks, the policy implementation process, and skill development to shape programs. This text will help us in the field and play a pivotal role in one of the greatest challenges of our times.

Robyn Golden, LCSW
Director of Older Adult Programs
Rush University Medical Center
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Illinois Chicago, who enabled me to bring together my backgrounds in public health and social work, and synthesize these two professional arenas—Dr. Lou Rowitz and Dr. Regina Kulys.

Lastly, I would like to acknowledge my family for their patience, understanding, unconditional support, and never ending “cheerleading”. Bill and Robert deserve special mention for the many nights they spent home alone while I tapped away on the computer keys!
This part lays out a background as to the current and future demographic trends of older adults and makes the case for the reader that there are a variety of philosophical, political, economic, and social factors that affect public policy development. The chapters help the reader explore a range of perspectives that define, shape, and impact the development and implementation of public policy. This part is also intended to prepare the reader to be able to critically analyze public policies related to aging. It sets the stage for understanding the demographic, social, political, and philosophical perspectives to policy development. The policy overview journey sets out with a glimpse of factors that play a role in policy and program development.
Background and Demographic Profile of Older Adults

PREPARING FOR THE “BOOM”

America is graying at a faster rate than ever before. In 2006, the first baby boomer turned 60 and became eligible for Older Americans Act Services. Baby boomers are a distinct group, with attitudes and values unlike the seniors who have preceded them. This group of aging individuals thrive on choice, seek out information, are consumer-oriented and demanding, and want their independence. Are we prepared to deal with the policy and program needs this group will present and need? Are we ready to address the gaps in services that this group will be demanding of us? How will social service and public health practitioners and policy makers be prepared for community and individual needs? What are the realities for current services, and what visions will be presented from baby boomers for new or revised services? What paradigms shape services that are currently in place, and how can we revise these services using tools for program planning and policy development?

Before we can address these issues, an exploration of the current demographic face in America is necessary. What does our landscape look like, and how do we anticipate that demographic changes will shape our social and community needs?
Life expectancy has dramatically increased over the past century. At the turn of the twentieth century (1900), life expectancy was 47 years of age (Pickett & Hanlon, 1995). In 1958 the life expectancy of adults increased to 68 years, and by 1991, the life expectancy was 76 years, while in 2003 life expectancy in the United States was 77.6 years of age (Centers for Disease Control and Prevention, 2005a). Hand in hand with these changes, there has been an increase in the number of elderly living within the United States over the past century. In 1900, 4% of the population was over 65 years of age, while it reached 12.7% by 1997 (nearly triple). The American Association of Retired Persons (AARP, 1998), based upon U.S. Census, estimates that by the year 2010, at least 28% of the population will be over 65 years of age. Table 1.1 illustrates these demographic changes over time.

Interestingly, approximately 1 out of about every 8 Americans falls into the older adult population. The number of older Americans has increased by nearly 11% since 1900 (compared to a 9% increase in the under-65 population) (USDHHS AoA, 2006). As the clock ticks away, every 8 seconds a baby boomer turns 60 (U.S. Census Bureau, 2006). Figure 1.1 provides an overview of this demographic shift.

The older population is expected to double over the next 30 years. The 85 and older group is expected to grow faster than any other group (Federal Interagency Forum on Aging-Related Statistics, 2006). In the last U.S. census, there were an estimated 66,000 centenarians; by 2050 there are expected to be 834,000. See Figure 1.2. Thus, our population profile appears to be growing older and grayer.

**TABLE 1.1 Demographic Changes of an Aging Population in the United States Over Time**

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage of the population 65 years of age or older.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1900</td>
<td>4.0</td>
</tr>
<tr>
<td>1920</td>
<td>4.6</td>
</tr>
<tr>
<td>1940</td>
<td>6.8</td>
</tr>
<tr>
<td>1980</td>
<td>11.3</td>
</tr>
<tr>
<td>1990</td>
<td>12.4</td>
</tr>
<tr>
<td>2000</td>
<td>12.0</td>
</tr>
<tr>
<td>2005</td>
<td>12.3</td>
</tr>
</tbody>
</table>

It has been estimated that the fastest growing group of older adults is the 85-year and older group. It is estimated by the U.S. Census Bureau that approximately 19 million people will be 85 or older in the United States by 2050 (see Figure 1.3).

FIGURE 1.1  Population projections of older adults for the year 2030.  

**CHANGES IN OUR POPULATION PROFILE**

FIGURE 1.2  Population breakdown by age group.  
*Note:* Data for 2010–2050 are projections of the population. 
Data refers to resident populations and noninstitutionalized individuals.  
*Source:* U.S. Census Bureau, Decennial Census and Projections.
During the twentieth century in the United States there was a significant gender shift among the aging (65+ years). In 1900, The U.S. Bureau of the Census reported that there were 108.5 men for every 100 women. In 1950, this ratio declined slightly; however there were still more men per 100 women (102.3 men per 100 women). In 1960, there were equal numbers of women per men (100 men per 100 women). By 1980, there were only 69.7 men per 100 women, and by 1990 the ratio had dropped to 64.1 men per 100 women, as shown in Table 1.2. By 2005, this ratio has increased to 74.5 men per every 100 women at 65 years of age or older.

### Table 1.2 Changes in Population Profile: Males and Females

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of males per 100 females</th>
</tr>
</thead>
<tbody>
<tr>
<td>1870</td>
<td>111.4</td>
</tr>
<tr>
<td>1900</td>
<td>108.5</td>
</tr>
<tr>
<td>1950</td>
<td>102.3</td>
</tr>
<tr>
<td>1960</td>
<td>100</td>
</tr>
<tr>
<td>1980</td>
<td>69.7</td>
</tr>
<tr>
<td>1990</td>
<td>64.1</td>
</tr>
<tr>
<td>2000</td>
<td>63.3</td>
</tr>
</tbody>
</table>

These dramatic shifts in numbers, especially over the past 40 years, will leave more women living alone and widowed, while men will be more likely to remain married or attended by women. Other implications of this will include the need to target income support mechanisms and social support programs for widowed and single women. This will have multiple effects on policies related to supplementary security income (SSI), Disability Insurance (DI), and Medicare, especially funding. Statistically, more men are married who are older adults (77%), when compared to women (43%), and more women are widowed (45%) as compared to men (14%). Only 4% of men and women are found to be single (never married) and 8% of both groups are separated or divorced (U.S. Bureau of the Census, 2005). Figure 1.4 provides an illustration of these statistics.

Living Arrangements

As to marital status, it is no surprise that men were more likely to live with spouses (72.4%) as compared to women (41.6%), while more women tended to live alone or with nonrelatives (41.6%) as compared with their male counterparts (21.5%). Women were also more likely to live with other relatives (16.8%) as compared to men (6.1%). Figure 1.5 provides an illustration of these data (USDHHS AoA, 2003).

A number of interesting trends have occurred between 1970 and 2004 among both men and women with regard to living alone. The number of men living alone has steadily increased among men aged 65 to 74

![Figure 1.4](image-url)
years of age (11.3% in 1970 to 15.5% in 2004). Men living alone in the 75 and over age category have also steadily risen from 19.1% in 1970 to 23.1% in 2004. Women between the ages of 65 and 74 have slightly dropped in number in terms of women living alone (31.7% in 1970 versus 29.4% in 2004). The age group that has had the most drastic rise in people living alone is the 75 years of age and over category (37% in 1970 as compared with 49.9% in 2004) (USDHHS AoA, 2003). Figure 1.6 provides an overview of these data.

**Education Level**

Today older adults are increasingly more educated than the previous generation. In 1965 only 23.5% of adults 65 years of age and older had

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**FIGURE 1.5** Living arrangements of people 65+ years.

*Source: Administration on Aging, 2001.*
completed high school degrees as compared to 48.2% in 1985 and 73.1% in 2004 (USDHHS, AoA, 2006). Similarly, there has been an increasing trend to attend college and complete a bachelor’s degree. In 1965, only 5% of older adults 65 years of age and older had completed a bachelor’s degree, as compared to 9.4% in 1985 and 18.7% in 2004. Figure 1.7 provides an illustration of these data.

Despite improvements in the overall education level of older adults over the past few decades, disparities still exist across ethnic groups. In 2004, non-Hispanic whites were the most educated when compared to African Americans, Blacks, Asians, and Hispanics. Whites aged 65 years and older were more likely than any other group to complete high school (73.1%) and a bachelor’s degree (18.7%), as compared to Blacks (52.5% completing high school and 10.7% completing a bachelor’s degree) or Hispanics (37.6% completing high school and 8.3 percent completing a bachelor’s degree). These variations in education level pose implications for the development of innovative resources, teaching tools, and training initiatives that may need to be tailored for the various educational levels. Figure 1.8 provides an overview of this data.

**Economic Well-Being**

Over the past several years there has been much debate about privatizing the Social Security program. Although there may be a portion of the population within a high income bracket category that could afford to invest money for their future (15% of people over the age of 65 years
have incomes of $75,000 or more), the majority of families with the head of the household over 65 years of age (53%) are families living below $35,000 per year (see Figure 1.9). When one further explores this issue and examines the distribution of income among people 65 years of age and older, it is found that 87% of this group are receiving less than $35,000 per year (see Figure 1.10). These limited funds make survival difficult within one’s retirement years, without some financing alternatives such as “reverse mortgages” and other creative financing options.

FIGURE 1.7  Education attainment of people 65+.

*Notes*: Data are based upon the Census Bureau question: “What is your highest grade or degree completed?”

Data refer to noninstitutionalized civilians, 65 years of age or older.


FIGURE 1.8  Education by race and Hispanic origin.
When considering sources of income for people 65 years of age and over, it appears that there is a trend towards reliance upon Social Security income, more so in 2004 (39%) as compared to 1962 (31% support). Pensions were also increasingly important (20% of income in 2004) as compared to 1962 (9% pension income). Asset income in 2004...
accounted for 13% of total income as compared to 16% of total income in 1962. Table 1.3 provides an overview of these data.

Despite these concerns about income, older adults 65 years of age and over are not actually the most prevalent group living in poverty over time. When compared to individuals younger than 18 years of age, or people 18 to 64, more of the youngest age group were noted to be in poverty (17.8%) when compared to other age groups. Among individuals over the age of 65, the oldest group of people were the most likely to be living in poverty. People 85 years of age and older were noted to have 12.6% of their cohort living in poverty, as compared to 9.8% for all individuals 65 years of age and older. Figure 1.11 shows these data.

### Changes in Rural Population

Although there has been a well-documented shift from agrarian/rural-based population to urban settings, the proportion of people living in rural settings (<9,999 people) has remained relatively stable over the past 30 years. At the turn of the twentieth century, 39.8% of the population lived in rural settings. This percentage increased steadily until 1950, when nearly three-fourths of all Americans lived in rural settings (71.2%). Between 1950 and 1960, nearly 50% of people living in rural

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</tr>
</thead>
<tbody>
<tr>
<td>Social Security</td>
<td>31</td>
<td>39</td>
<td>39</td>
<td>36</td>
<td>38</td>
<td>38</td>
<td>39</td>
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<tr>
<td>Asset income</td>
<td>16</td>
<td>18</td>
<td>22</td>
<td>24</td>
<td>20</td>
<td>18</td>
<td>13</td>
</tr>
<tr>
<td>Pensions</td>
<td>9</td>
<td>16</td>
<td>16</td>
<td>18</td>
<td>19</td>
<td>18</td>
<td>13</td>
</tr>
<tr>
<td>Earnings</td>
<td>28</td>
<td>23</td>
<td>19</td>
<td>18</td>
<td>21</td>
<td>23</td>
<td>26</td>
</tr>
<tr>
<td>Other</td>
<td>16</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>2</td>
<td>3</td>
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<td>Total</td>
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<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

**Notes:** Income is aggregated by source for selected years, 1962–2004, represented as percentages. The definition of “other” includes, but is not limited to, public assistance, unemployment compensation, worker’s compensation, alimony, child support, and personal contributions.

Data refers to noninstitutionalized populations.

settings migrated to urban settings, dropping from 71.2% to 37.5%. The percentages have remained relatively stable over the last 40 years with slight decreases in rural populations from year to year.

The rural demographic portrait becomes more descriptive, particularly with regards to the proportion of people living in rural areas who are 65 years of age and over and who live in very small rural communities (<2,500 people). Table 1.4 outlines this demographic shift.

**FIGURE 1.11** Percentage living in poverty—a comparison across the life span.


<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage of the population living in rural settings</th>
</tr>
</thead>
<tbody>
<tr>
<td>1900</td>
<td>59.8</td>
</tr>
<tr>
<td>1950</td>
<td>71.2</td>
</tr>
<tr>
<td>1960</td>
<td>37.5</td>
</tr>
<tr>
<td>1970</td>
<td>33.5</td>
</tr>
<tr>
<td>1980</td>
<td>32.7</td>
</tr>
<tr>
<td>1990</td>
<td>30.8</td>
</tr>
<tr>
<td>2000</td>
<td>24.6</td>
</tr>
<tr>
<td>2005</td>
<td>n/a</td>
</tr>
</tbody>
</table>

This demographic picture is further compounded by those who were foreign-born and are living in rural areas, as shown in Table 1.5. These are foreign-born people who immigrated to the United States and are living in Frontier Rural Communities (referred to areas of <2,500 people) or who live in rural communities (2,500–9,999). While there has been a decrease (over 50%) of foreign-born people living in rural areas (59.8% in areas of <2,500 people; 14.3% in areas of 2,500–9,999 in 1900 versus 24.8% Frontier Rural in 1990 and 6.0% in rural communities with a population of 2,500–9,999, respectively), there have been more women than men 65 years of age and older and more foreign-born people residing in smaller rural centers.

The number of foreign-born people residing in small rural areas or Frontier Communities (<2,500) who are over 65 years of age raises some serious concerns about the need for services, which may need to be culturally sensitive and culturally diverse. These services may also need to address such issues as cultural expectations around help-seeking behaviors, the role of religion and mortality, the aging process, loss of independence, and expectations around social supports. Language barriers may also play a role in the delivery of services and access to services within rural communities. (See Table 1.5.)

**Trends in Morbidity and Mortality**

Over the last century there have been dramatic changes in the facts of morbidity for older adults. This is due to technological advances, changes

<table>
<thead>
<tr>
<th>Year</th>
<th>&lt;2,500</th>
<th>2,500–9,999</th>
<th>%65+</th>
<th>Males</th>
<th>Females</th>
<th>Rate: Males/Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>1900</td>
<td>59.8</td>
<td>14.3</td>
<td>9.2</td>
<td>8.8</td>
<td>9.7</td>
<td>108.5</td>
</tr>
<tr>
<td>1910</td>
<td>53.7</td>
<td>24.3</td>
<td>8.9</td>
<td>8.1</td>
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<td>4.2</td>
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*Sources: Gibson & Lennon (1999) and United States Census Bureau (2005).*
in quality of life and living conditions, and advances in medicine. In 1900, the leading cause of death for people 40 years of age and older was tuberculosis, while for women it was childbirth (Picket & Hanlon, 1995). According to the National Health Interview Survey (CDC NHIS, 1997) the leading cause of morbidity in 1994 for people 65 years of age and over was arthritis (50 per 100). Hypertension was the second leading cause of morbidity (36 per 100) followed by heart disease (32 per 100). The changes in morbidity leads to a need for renewed public health, health promotion, and health education strategies. New approaches will be necessary to accommodate these health promotion efforts, which have recently been identified within the Older Americans Act amendments of 2006. (See Table 1.6 and Figure 1.12.)

Recently there has been a change in perceptions about health among older adults. In 1995, 20.3% of the population 65 and older rated their health as fair to poor, as compared to 9.4% for the general population. However, there was a difference between general perceived health status of African Americans, 43% of whom reported their health as fair to poor. This compares to only 28% of Caucasians who reported their health as fair to poor (CDC NHIS, 1995). This suggests that there is a growing percentage of the population over the age of 65 who perceive themselves to be in poor health and an increase in disparity among people of color (CDC, 2005b). These data serve to illustrate the importance of interventions to target diverse groups. The differences in perceived health status will also have an impact on health promotion programs to target older adults and reach minority groups in meaningful ways. (See Figure 1.13.)

One’s perceived health status is also compounded by difficulties reported with carrying out activities of daily living (ADLs) by people 65 and over. Respondents in the National Health Interview Survey (1995) who identified themselves as being over 65 years old and were living independently within their community reported difficulties with carrying out both activities of daily living and instrumental activities of daily

<table>
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<th>TABLE 1.6 Rates of Morbidity</th>
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<td>Type of illness</td>
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<td>Cataracts</td>
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<td>Orthopedic impairments</td>
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FIGURE 1.12  Health status related to chronic conditions of older adults.

Notes: Data are based upon the question “Have you EVER been told by a doctor or other health professional that you have some form of arthritis, rheumatoid arthritis, gout, lupus or fibromyalgia?”
Data refers to civilian, noninstitutionalized population.
Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

FIGURE 1.13  Perceived health status—comparing for ethnic diversity.

Notes: Respondents reported that they were in good to excellent health. Target population was noninstitutionalized civilian adults, 2002–2003.
Data is averaged.
Source: National Health Interview Survey, National Center for Health Statistics, Centers for Disease Control and Prevention.
living (IADLs). Activities of daily living, characterized as bathing, dressing, feeding, mobility, toileting, and transferring were reported as problematic for 14% of the noninstitutionalized population who were over 65 years of age. In addition, 6.5% of the population reported having difficulty with IADLs. These activities included meal preparation, shopping, managing money, taking medication, doing housework, and using the telephone. These difficulties will translate into needs for services to allow people to remain in their homes and communities. Increasingly, there will be people living in communities who will require assistance with basic ADLs and services to promote functional status and healthy living. Given that current health policies only support services that are “medically necessary,” a challenge for health educators and health promotion experts will be the development of health policy provisions to include health education and health promotion programs.

**CHANGES WITHIN THE SOCIAL, POLITICAL, AND CULTURAL EXPECTATIONS OF COMMUNITIES**

Up to this point, this chapter has highlighted some of the current health programs and policies in place and changes in demographic trends for older adults living within American society. In addition, there have been substantial changes within the social, political, and cultural expectations of communities over the past century that will pose challenges for policies and programs serving older adults.

Socially, health care has been impacted by numerous changes in gender roles and expectations over the last century (Kinsella & Gist, 1998). Women have become and continue to be active members of the community and maintain a high degree of civic engagement long into retirement. They have also retired after having had careers (GAO, 1997). Women have also begun to outnumber males, as they grow older. Along with this demographic shift, there are growing numbers of women who are independent of their husbands or in same sex/gender relationships. These social changes have generated new social policy needs for women (GAO, 1998).

As noted, there has been an increased mobility to urban centers from rural communities and a shift from agrarian to industrial communities. Despite this, many of the older foreign-born population and minorities have remained in rural communities, especially those with more severe functional impairments and disabilities. Coupled with smaller and more mobile families, this will lead to the need for alternative care models for people in rural areas as they grow older, and for service paradigms that will address the unique needs of rural communities.
Emerging service models that include community care and assisted living care models will serve as alternatives to traditional care of elders (Kovner & Jonas, 1999; Kronenfeld, 2000). Many of the traditional cultural expectations for families have eroded away as a result of cross-cultural or interracial marriages, smaller families, and more mobile family units. These changes to the social structure of families are resulting in changes and the need for differences in service composition for the older adult.

The shift from family to community support systems is another social change that will impact health care services (Atchley, 2000). Support provided by extended families and large families caring for the elderly has evolved into greater reliance on informal systems including the faith community, and formal systems such as local community-based service and philanthropic organizations. This leads to implications for the delivery of social programs through faith-based initiatives associated with local religious communities. Funding appropriations for such programming will need to be supported through some mechanism, either private donations or through some legislative mandate (Kaiser Commission on Medicaid and the Uninsured, 2001).

In summary, demographic changes; educational levels; income levels; and shifts in social, cultural, and service expectations of communities will contribute to changes in social services, programs, and policy initiatives as we move into the twenty-first century. These will pose challenges to the aging arena and to aging policies and programs.

### CHALLENGES FOR AGING POLICIES AND PROGRAMS

Several issues emerge as realities within the context of policy development and program planning for older adults, as we have seen in this chapter. These include: changes in living arrangements, education levels, economic well-being, rural population settings, trends in morbidity and mortality, and changes within the social, political, and cultural expectations of communities. These changes lead to challenges to the current realities of our aging policies and service delivery network. Communities and service providers will also be challenged to prepare for the upcoming onslaught of baby boomers, who will challenge paradigms, and will be consumer-driven. The realities of our system will require professionals working within the field of aging to challenge the current contexts, take a hard look at what exists in reality, and develop strategies to envision an innovative set of interventions, services, and policy/legislative initiatives (Binstock, 1998, Derthick, 1979, Hiller
& Barrow, 1999). Such an approach will demand a new skill set that may be foreign to the current workforce. Such skills will include an in-depth understanding of what factors and contexts impact legislative initiatives, paradigms that affect the development of legislation, and data that may influence or contribute to policy development. Tools such as coalition building, media advocacy, and theoretical perspectives on health behavior are also going to be critical in this endeavor. Finally, building an awareness of what programs and services currently exist will also be a part of this process. Hence, this lays the groundwork for the remainder of this text, which is broken out into four distinct parts, and designed to address each of the skill areas required to enable reflective practitioners to build on their skills and be effective program and policy advocates in the aging arena.

REALITIES AND VISIONS

In summary, health policies related to aging in the United States have focused on in-kind medical services, supportive state and local services, and antipoverty benefits. Despite the availability of programs and services resulting from health policies, many programs are focused upon “medically necessary” services and lack a health promotion or health education focus (Torres-Gil, 1998; Torres-Gil & Villa, 2000). A challenge for health professionals working with the elderly will be to lobby for social policies that will offer health education and health promotion options to maintain a healthy elderly population. The benefits of such advocacy efforts will include the development of a more active and healthy elderly population leading to cost containment and the preservation of current benefits and programs available to the elderly living in the United States.

REFERENCES


