AMERICA'S AGING POPULATION AND NATIONAL POLITICS: A YEAR 2000 PERSPECTIVE

VOLUME I

A Dissertation

by

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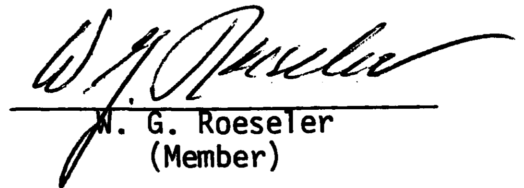

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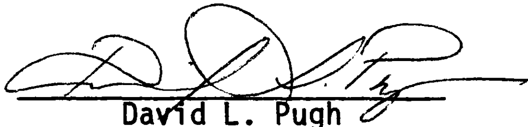

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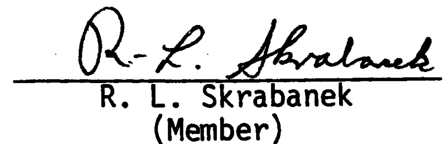

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ABSTRACT

America's Aging Population and National Politics:
A Year 2000 Perspective. (May 1983)

Volume I

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The purpose of this Delphi study was to undertake and complete an interdisciplinary investigation of the degree of probability that exists, in the opinion of the members of an expert panel, that persons 65 years of age and older will become an effective and viable political force at the national level in the next twenty years.

Based on a survey of the fields of psychology, sociology, economics, and the health and political sciences, a propositional inventory was constructed for use in the Delphi study. Only top ranking policy makers were invited to participate in this study.

The major findings of this study were:

1. Elderly persons will, in the time period under study here, begin to possess sufficient group consciousness to identify themselves as members of the elderly group and to vote as a political bloc--but only on certain political issues.

2. By unanimous agreement by the members of the panel, the political issues considered to be of most importance to elderly persons were Social Security and Medicare.

3. It is forecasted with a high degree of probability that both major political parties in the United States will continue over the next two decades to appeal to the elderly voter by appearing to back various provisions of both the Social Security (OASI) and the Medicare programs.

4. The probability is high that members of each of the two major political parties in the United States will strive to project the image that the members of its own party are the major political support for Social Security (OASI).

5. Last, the issue of "party switching" by elderly voters over the next two decades is rated as a possible occurrence of only "medium probability." This is the most surprising forecast of the entire study, in light of current happenings on the political scene today.

DEDICATION

Dedicated To

Lennie-Marie P. Tolliver, Ph.D.

United States Commissioner on Aging

ACKNOWLEDGMENT

It is with considerable humbleness that I acknowledge the highly capable support that I received from not one but two committee chairmen and from all three of the fine gentlemen, Dr. Skranbanek, Dr. Pugh, and Dr. Roeseler, who served as members on my committee. My first committee chairman, Professor Don Sweeney, was instrumental in helping me in the initial design of this research study while the second and present committee chairman was instrumental in helping me execute that research design. In addition, the three committee members maintained an "open door" policy for me over the several years of this research. Without the many contributions of these scholars, this project could never have come to fruition.

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CHAPTER I

INTRODUCTION

The twentieth century has brought many significant changes to the United States, one of which is a rapid change in population. Reviewing the general population figures in the United States for selected years from 1900 to 1980 reveals that the population in 1900 was 75,994,574; in 1920 it was 105,710,620; in 1940 it was 131,669,275; in 1960 it was 178,464,236; and in 1980 it was 226,504,825 (Statistical Abstract, 1981:5).

Within the changes for the overall population figures for the United States, there are several subsets of population figures which also show a series of rapid changes for the same time frame. Of particular interest in this research study is the subset that relates to the total population figures for the elderly population, or those persons who are 65 years of age or older.

For example, in 1900 the 3,100,000 elderly Americans made up only 4.1 percent of the total population. By 1950, however, the number of elderly Americans had actually quadrupled to 12,397,000 and their proportional share of the population had doubled to 8.2 percent. Based on the figures for 1950, it was projected that by 1980, the number of elderly Americans would double, reaching almost 25 million or 11 percent of the total American population, which, in fact, they surpassed (Future Directions, 1980:1).

This dissertation follows the style and format of the Journal of Educational Research.

Brotman (1979:354) recently completed a series of three separate population projections through the year 2000. The second of these three population projections is cited here as this series is apparently based on the most realistic assumptions. These assumptions include an ultimate fertility rate of 1.7 as opposed to the present 1.8 figure in this area. Of course, with the forecasted birthrate figures decreasing slightly, there will be a slight increase in the proportion of elderly persons contained within the projected population figures.

Brotman's figures project the population of the group that is 65 years of age and over at 11.4% for 1985; 11.8% for 1990; 11.9% for 1995; and 11.7% for the year 2000. Consequently, a slow growth rate is forecast for this age group throughout the 1980's and a "no-growth" rate, throughout the 1990's.

A different pattern is formed if the projections are for the growth rate of all persons 55 years of age and older. In that case, the projection holds relatively firm at 20 percent of the total population from 1980 through the year 2000; that is, one out of every five persons in the United States is presently in the age range entitled "older adult," and this figure will remain relatively constant throughout the rest of this century (Brotman, 1979:354).

Nevertheless, there are other reasons, besides sheer numbers, why older adults are not likely to be ignored in the future. Not only will the actual number of older people continue to increase but more importantly, perhaps, the "quality" of these people will also continue to increase as well, at least through the year 2000. Quality here refers to the average educational level of the American population

that is 65 years of age and older. Moreover, a change in educational level (i.e., an upward trend) will bring with it a whole host of changes which are summarized here as changes in life style.

Hendricks and Hendricks (1981:77) state:

> Between 1940 and 1980, the average educational level among Americans 65 and over climbed from 8.1 to 9.7 years of school; by 1990 the average will increase another two years. During the same interval, the number of elderly who had graduated from high school rose from one in ten to four in every ten. Over the next decade the proportion of older citizens who are high school graduates should reach 50 percent. Interestingly enough, many of the attitudes thought to be characteristic of older people are not related so much to their age as to their education. A number of the existing stereotypes concerning rigidity, conservativeness and so on will be challenged as a larger proportion of our older population attain a higher level of education. A second but related factor is the length of time that has elapsed since a person's education was completed. The farther removed from his or her training an older person becomes, the more old-fashioned or rigid his or her outlook appears to younger observers. By altering the structure of educational opportunities in the United States and other industrialized countries, the major artifact of the datedness of older people's attitudes could be overcome.

Thus, not only are slightly over 30,000,000 older adults forecast for the year 2000 (Palmore, 1980:436), but half of them are also projected to be at least high school graduates (Hendricks and Hendricks, 1981:77), an educational level for older adults totally undreamed of in the early years of our nation.

While it is true that the members of the age group that are 65 years of age and older will be better educated in future years than members of prior comparable cohorts, the members of these future cohorts are not as likely to be in the category of "employed persons" as members of this group have been in past years. For example, in 1900 approximately two thirds of the males 65 years of age and older

were still grainfully employed. By the start of World War II, this figure had dropped to 42 percent. In 1970, this figure had decreased to slightly less than 25 percent (Cowgill, 1974:8). The 1980 census figures are not available in this area at this time; however, it is forecasted that these figures will indicate even fewer older persons employed in the year 1980 than the census did in 1970.

Illustrating the general "median income" rule, which states that, on the average, the median income of a retired family is half that of all the families in the nation, Cowgill (1974:9) states:

> Thus, retirement usually entails a considerable curtailment of income. In the United States in 1969 the median income of families headed by persons 65 and over was only half the median of that for all families; $4895 as compared to $9596. There is therefore a financial penalty attached to aging in modern societies.

As has already been shown, the United States has both a large number and proportion of older adults. Many of these persons are forced to be nonproductive; and, as Cowgill (1974:16) states, "they are penalized for their nonproductiveness with reduced incomes and relatively low status."

The "young old" (see definition on page 11) represent a more mixed situation. For example, utilizing just the data relating to white families in the year 1970, those families headed by a person classified as "young-old" had a 15 percent lower income than did families headed by a person in the 45- to 54-year old range. Of course, for the family headed by a person 65 years of age or older this drops to approximately half of the average family income of those families headed by a 45- to 65-year-old person (Neugarten, Hanighurst & Tobin, 1968:177).

Early retirement or retirement before the age of 65 has been the general trend from at least 1945 through 1980. The employment rates for men over 65 are presently less than half the employment rates for the members of this age group established in 1950. In 1980, only 62 percent of the men in the age range of 60 to 65 were still in the labor force. This figure for the 60- to 65-year-old age group, as recently as 1960, was 78 percent (Income, 1981:5).

The category of "older adults" (see definition on page 10), on the average, suffer from a series of social and physical disadvantages of one type or another. For example, not only are the changes for employment reduced for older adults, but incomes are drastically reduced as well. Also, members of this group suffer from a series of health problems, both physical and mental. These occur precisely at the time in the lives of many of these older adults when they can least afford the costs of the medical services required to help them maintain or regain their health. For example, Harootyan (1981:74) states:

> The statistical profiles of the older population uniformily supported the popular conception of the aged American as sicker, poorer, and less insured than his or her younger compatriots. Health surveys reported and continue to indicate that persons age sixty-five and over are more than twice as likely as those under age sixty-five to be chronically ill and to be hospitalized twice as long.

It is true that most of the "young-old," as defined by Neugarten, Havighurst and Tobin (1968:177) (see definition on page 11) are, if concerned with health at all, primarily concerned with conserving and maintaining their health (Executive Summary, 1981:1).

In view of the large growth in both numbers and proportions of older adults over the past 80 years and with this segment of the population exposed simultaneously to both higher health risks and lower incomes with which to obtain medically related services, it should come as no surprise that action on the part of government agencies would be required to deal with these and many other problems; however, "focusing on the needs of the elderly is a relatively recent political development . . ." (Harootyan, 1981:78). It is only very recently that the members of the "65 years of age and older group" have constituted more than 10 percent of the total population of the United States. With the increasing numbers and with the increasing educational levels, the members of this group have become a highly visible segment of the total population. Also, with the increase in numbers and the average educational levels, the members of this group have become a potential political power that did not exist on the American political scene previously.

With the economic and medical problems of the older adults well documented, the members of this group have definable interests that require a definite "political statement" on their part. It does not matter whether the older adults, as a group, make this statement or whether other organized bodies make the statement for them. In the American political arena, interest-group liberalism seems to dominate, and only organized groups, as such, can apparently make much of a political impact.

Lowi (Lowi, 1969:71) states that interest group liberalism is based on the following assumptions:

> (1) Organized interests are homogeneous and easy to define, sometimes monolithic. Any "duly elected" spokesman for any interest is taken as speaking in close approximation for each and every member. (2) Organized interests pretty much fill up and adequately represent most of the sectors of our lives, so that one organized group can be found effectively answering and checking some other organized group as it seeks to prosecute its claims against society. And (3) the role of government is one of ensuring access particularly to the most effectively organized, and of ratifying the agreements and adjustments worked out among the competing leaders and their claims. This last assumption is supposed to be a statement of how our democracy works and how it ought to work. Taken together, these assumptions constitute the Adam Smith "hidden hand" model applied to groups.

Of course, interest-group liberalism is based on group consciousness. It is much more than group consciousness, however; but without this consciousness as a base, it is not readily apparent how a group could effectively enter into the "democratic political game," which is dominated by interest-group liberalism.

There are problems in forming group consciousness among the older adults based solely on age. Harootyan (1981:78) states: "One of the greatest obstacles to formation of a group consciousness, especially a politically homogeneous one, is that elderly persons are subject to many competing identities and allegiances. The older population is economically, socially, and politically heterogeneous."

Yet, since the older adults have increased in both number and proportion of the total population, as well as having increased in average educational level, it would seem that this segment of society does, in fact, possess a new potential as a political bloc within the democratic process described as "interest-group liberalsim" with which to address various issues. For example, should an increasing porportion of the older adults, in the future, identify with the older adult

group, say, along specific political issues lines, and should these older adults see themselves as politically discriminated against, especially in such areas as the Social Security income maintenance program or in the area of Medicare, considerable potential seems to exist to indicate that the older adult could, in fact, be encouraged to make a strong political statement in the political arena under the present rules of "interest-group liberalism."

The remainder of this section is devoted to the following subjects: (1) the purpose the study, (2) the definition of terms used, (3) the methodology, and (4) the limitations of the study.

The Purpose of the Study

The purpose of this research study is to undertake and complete an interdisciplinary investigation of the degree of probability that exists, in the opinion of the members of an expert panel, that persons 65 years of age and older will become an effective and viable political force at the national level in the next twenty years.

The present research study differs in an important manner from the previous research studies reflected in the literature. Instead of involving researchers, academicians, scholars or writers in a futures policy study relating to aging politics, this research study involves personnel within two of the three "main actor" groups--the decision makers in the aging-oriented organizations and government policymakers. This means that personnel actively involved in aging-oriented policymaking will also be actively involved in forecasting various future probabilities relating to the older adult as a viable and effective

political force. The results may differ significantly from those that are produced when various highly credentialed experts who are "outsiders" react to the same propositional data set.

Built into this study is a type of correctional device. As members of the aging-oriented organizations tend, by tradition, to be optimistic about the older adult becoming more politically effective in the future and as national-level politicians tend, by tradition, to be pessimistic about this issue, these two data sets will permit the implementation of the arithmetic procedure referred to as "averaging toward the mean." This will tend to eliminate extreme fluctuations in the overall data set. Of course, the final data set and the two data subsets will be presented in such a manner that direct comparisons can be made between and among the various data groups.

The Definition of Terms

The following definitions apply throughout this study for the terms cited below:

Actor--a respondent taking part in a Delphi exercise; also called "player."

Aging--a process that commences at a socially prescribed time, usually at conception or at birth; a general term used for persons 65 years of age or older; i.e., the aging population.

Delphi Study Method--an iterative group process that utilizes written responses as opposed to bringing individuals together; this method or technique narrows group consensus by providing the partici-

pants with a set of the first round responses, asking them to reconsider their respective responses vis-a-vis over all group response pattern in a second round, with possibly a third and last round closing the question-response cycle.

Elderly--a traditional term designating all persons 65 years of age or older.

Frail Elderly--a specific term designating all persons 75 years of age and older; the frail elderly are a specialized subgroup within the elderly group referred to in the preceding definition.

Iteration--relating to or being a computational procedure in which replication of cycle of operations produces results that approximate the desired results more and more closely; a phase of the Delphi study; also called a "round" (see "round").

Older Adults--a specific term designating all persons 55 years of age and older.

Policy--a definite course or method of action selected from among alternatives in light of given conditions to guide and determine present and future actions; a high-level overall guideline embracing the general goals and acceptable procedures, especially of a governmental body.

Policymaking--the high-level elaboration of policy, especially of governmental policy.

Probabilistic Environment--that environment, of a probabilistic nature, which, according to the consensus of the top policy-makers, authorities and specialists, will occur during a specific time period in a specific place.

Propositional Inventory--a type of survey instrument composed entirely of a series of statements or propositions as opposed to a series of questions.

Round--an iterative phase of a Delphi study; a complete cycle where a respondent is sent a propositional inventory, annotates the propositional inventory, and returns it to the office of origin.

Technological Forecasting--an attempt to formulate a logical statement about a probabilistic environment in which alternate possibilities and consequences are given in-depth study usually by members of a multidisciplinary team.

Young-Old--a specific term that designates all persons 55 to 65 years of age; not to be confused with the definition for this term supplied by Neugarten who utilizes the age parameters of 55 to 75 for this group.

The Methodology of the Study

This research study is an interdisciplinary investigation of the degree of probability that exists that persons 65 years of age and older will become an effective and viable political force in the next twenty years. The research design involves a series of sequential steps to attain this goal.

The first step in the execution of this research design is to determine which of the social sciences will contribute significant information to the primary problem under consideration, i.e., the degree of probability that exists that persons 65 years of age and older will become an effective and viable political force in the

next twenty years. Because the following academic disciplines appear to offer the greatest possibilities of further enhancing the knowledge base in relation to the primary problem under consideration, they were chosen for inclusion in this study: demography, psychology, sociology, economics, and the health and political sciences. The area of educational attainment of the older adult is treated as a social science under the heading of vital statistics in the section on demography.

The second step is to review in detail the theoretical positions of the various issues considered to be germane to the central issue under discussion in each area of the social sciences cited above. This is an ambitious undertaking which demands that only those issues considered to be of vital concern to the central problem proposed in this research be investigated. At the very best, the findings in the area of the various social sciences selected for investigation here will be voluminous; consequently, considerable discipline must be exercised to insure that the research efforts remain consistent with the stated purpose of this research study.

The third step involves a thorough review of the two major issues that apparently possess the strongest forecasted possibility of bringing the older adults into a viable and effective political force. These issues appear to be those of the Social Security (Old Age and Survivors Insurance) program and the Medicare (Medical Insurance) program. Again, a great deal of discipline is required to stay with the issues that directly support the stated purpose of this research study. Even at the very best, the amount of literature that must be

closely examined in the areas of Social Security and Medicare is voluminous. In addition, brief references must be made to the two public welfare programs that compliment the Social Security and the Medicare programs. These are the Supplemental Security Income and the Medicaid programs.

The fourth step is to identify the various groups of actors, other than the older adults themselves, that possess the most discernable and influential roles in assisting or preventing the older adult in becoming an effective and viable political force in the future. Passing over both the general adult population as well as all voters in national elections in general as too broad, two groups of actors stand out from all the groups making up the larger society. These groups are the aging-oriented organizations and certain readily identifiable policymakers at the national level. This includes both politicians and personnel in one of the key governmental agencies at the national level designed to influence public policy as it relates to the older adults of the nation, the Administration on Aging.

The fifth step is to identify ten top-level policymakers presently either serving in the U. S. Congress or who are presently employed by the U. S. Government's Administration on Aging and write them to participate in the research study. Also, particular effort must be made to identify the nationally recognized authorities in the area of health care for the elderly and in the area of Social Security and include these persons in this respondent group.

The five largest voluntary aging-oriented organizations are the National Council of Senior Citizens, the National Retired Teachers

Association, the American Association of Retired Persons, the National Association of Retired Federal Employees, and the National Council on the Aging. Ten top-level policymakers from these organizations will be identified and asked to participate in this research study.

The sixth step is to initiate and carry to completion, the Delphi study while the seventh and last step is to analyze and report the results of the study.

The Delphi Study Rationale

The single most extensive research on the various techniques utilized in technological forecasting throughout the contemporary world is the study by Jantsch, a British scholar of some note. The Jantsch Study (Jantsch, 1967), citing in rank order over 100 of the most important methods used in technological forecasting, assigned the various techniques to three major divisions--a technological development environments division, an aggregate levels division, and a social technology environments division. In all three major categories, the Delphi study, also referred to as the Delphi technique, was positioned in first place as the most used technique in technological forecasting.

Erick Jantsch (Jantsch, 1967:37) states:

> The "Delphi" technique has been developed to improve the consensus between scientists and other experts. It May become an important tool for the selection of social goals, national objectives and broad missions. The problems of future high level goals will be considerably complicated by the logical extension of the simple matching of exploratory and normative technological forecasting to

> feedback systems. The future goals will then not only be forecast along the lines of highest probability, but anticipations (known also as "possible futures," "alternative futures," and "future goals") of less probable, but possible, consistent future goals and situations will be systematically explored and will, in an iterative feedback loop, be permitted to influence current decisions as well as the orientation of exploratory forecasting.

The Delphi technique has been used frequently in the areas of health, education, social policy, public policy, as well as in the area of gerontological policy (Beatty, 1978, Bolton, 1978; Clark & Cochran, 1972; Donahue, 1960; and Gerjuoy, 1977). The work by Kleemeier, Havighurst and Tibbitts (1957) is especially noteworthy in the area of gerontological policy. Clark Tibbitts in particular later went on to do important work in this area.

The June 1980 issue of The Gerontologist is devoted, in large part, to a Delphi study (The Foundation's Project) conducted in the area of gerontology. Based on the recommendations found in this article, the probable success of any Delphi study is enhanced when the panel:

1. Are top-ranked policymaking persons.
2. Are actively involved in current duties that involve the authority and responsibility to formulate policy.
3. Are involved in current top-ranked policymaking positions in the field that is being investigated.
4. Are varied in professional backgrounds, training and experience.
5. Originate from different regions of the country.

The researchers of the Foundation Project (Foundation Project, 1981:9) summarize the Delphi method as follows:

> The Delphi method simulates the processes of group discussion and decisionmaking. Without physically bringing the participants together, the Delphi assembles their ideas, provides feedback, and facilitates retainment and revision of these ideas. Typically, this is carried out by means of a series of iterative questionnaires completed by a selected panel of individuals with relevant expertise. The first questionnaire elicits judgments on the problems being studied. Each subsequent questionnaire provides feedback in the form of statistical summaries of responses to the previous round of questionning and again asks the basic questions, often focusing on more specific aspects. Throughout the process, respondents are encouraged to explain their responses and to present arguments to refute judgments with which they disagree. These comments, presented in the subsequent questionnaire together with the quantitative feedback, are intended to encourage participants to reconsider their own views and, thus, to move the group toward consensus. After several iterations, usually three or four, maximum consensus has been reached and the process is complete.

The Expert Panel

Much of the strength of any Delphi study rests directly on the members making up the expert panel of respondents. Delbecq (Delbecq, 1975:89) states in reference to the Delphi method that "the size of the respondent panel is variable. With a homogeneous group of people, ten to fifteen participants might be enough." Consequently, ten respondents are included in each of the two main groups involved in this study. The total of the two groups, therefore, does not greatly exceed the recommended size of the "standard" respondent panel suggested by Delbecq.

The first group of 10 respondents represent the top governmental policymakers at the national level. This group is composed of a highly select group of U. S. Senators and U. S. Congressmen as well as a highly select group of policymakers assigned to the U. S. Government's

Administration on Aging. The members of this group are:

1. Mario Biaggi
   United States Congressman (D.,N.Y.)
   United States House of Representatives Select
   Committee on Aging
   Chairman, Subcommittee on Human Services

2. Alfred E. Duncker
   Deputy Commission
   Administration on Aging

3. Bryon Gold
   Deputy Commission
   Administration on Aging

4. Gene Handelsman
   Deputy Commission
   Administration on Aging

5. Edward M. Kennedy
   United States Senator (D., Mass.)
   United States Senate's Committee on
   Labor and Human Resources

6. Stanley N. Lundine
   United States Congressman (D., N.Y.)
   United States House of Representatives
   Select Committee on Aging

7. Charles H. Percy
   United States Senator (R., Ill.)
   United States Senate Special Committee
   on Aging

8. J. J. Pickle
   United States Congressman (D., Tex.)
   United States House of Representatives
   Ways and Means Committee
   Chairman, Subcommittee on Social Security

9. David Pryor
   United States Senator
   United States Senate Special
   Committee on Aging

10. Clark Tibbitts, Ph.D.
    Deputy Commissioner
    Administration on Aging

The second group of 10 respondents represent the five largest voluntary aging-oriented organizations. These organizations, which have been identified earlier in this section, are the National Council of Senior Citizens, the National Retired Teachers Association, the American Association of Retired Persons, the National Association of Retired Federal Employees, and the National Council on the Aging. The members of this group representing these organizations are:

1. George E. Auman, Vice President
   National Association of Retired Federal Employees
2. Horace B. Deets, Associate Director
   American Association of Retired Persons
   (Representing the National Association of Retired Teachers)
3. Gail Dratch, Director of Research
   National Council of Senior Citizens
4. David M. Goldenbaum, Director of Research
   National Association of Retired Federal Employees
5. Barbara Herzog
   Special Assistant to the Associate Director
   American Association of Retired Persons
6. William R. Hutton, Executive Director
   National Council of Senior Citizens
7. Richard Mantovani, Director of Research
   National Council of Senior Citizens
8. Jack Ossofsky, Executive Director
   National Council on the Aging
9. Hall Summers, Director of Research
   American Association of Retired Persons
10. Dorothy S. Washburn, Second Vice President
    National Association of Retired Federal Employees

The Limitations of the Study

1. This research study is limited to the data base provided by the responses of the members of the two separate groups involved in this study, as well as to major trends gleaned from a survey of the professional literature.

2. The study is limited to the probability forecasts of the future, as indicated by the annotations provided by the respondents, as well as the probability forecasts of the impacts of these occurrences.

3. The study is limited to the analysis and interpretation of data by one researcher, guided by the members of an interdisciplinary advisory committee, as opposed to the analysis and interpretations of several researchers representing various interdisciplinary specialities.

The Format of the Research Study

Chapter One of the research study introduces the problem statement and then presents a list of definitions of important terms used in the study. This is followed by a section on the methodology to be utilized in the research study. Chapter One is terminated with a statement specifying the limitations of the study.

Chapter Two utilizes a special gerontological approach in studying the older adult as a political actor. Such an approach is by necessity interdisciplinary. Clark Tibbitts (1960:22), who is one of the foremost scholars in the area of gerontology as well as being one of the top policymakers in this field, states:

> Social Gerontology is a new field of research and teaching which is not directly concerned with the biological aspects of aging but concentrates rather upon its economic, social psychological, sociological, and political aspects. Its object of research is not individual organisms, but people as population aggregates, as members of society and its component groups, and as the creators and the carriers of culture. Specifically social gerontology studies, the status and roles of older persons, their cultural patterns, social organization, and collective behavior as they are affected by and as they affect social change.

Consequently, Chapter Two contains sections devoted to demography, psychology, sociology, economics, and to the health and political sciences. The material in these sections relates directly to the central issue of the older adult as a political actor, and tends to reemphasize the potential that the older adult has in the political arena.

Chapter Three and Chapter Four present the characteristics of the two other political actors. Chapter Three reviews the past history and the present characteristics of the five main voluntary aging organizations to be included in this research study. Chapter Four reviews the administrative network that relates to national policy and to the older adult for both houses of the U. S. Congress and briefly reviews the administrative network of the Administration on Aging.

Chapter Five reviews in detail the Social Security (OASI) program and briefly reviews the Supplemental Security Income Program (SSI). The Social Security program represents an issue of great importance politically to the older adults of the nation. The Supplemental Security Income Program is briefly reviewed as this program provides a minimum income support to many older adults;

however, as a political issue, the Supplemental Security Income program is of only minor consideration in this research study.

Chapter Six reviews in detail the Medicare program and briefly reviews the Medicaid program. The Medicare program represents an issue of great importance politically to the older adults of the nation. The Medicaid program is briefly reviewed because this program provides health care for many older adults; however, as a political issue, Medicaid is of only minor consideration in this research study.

Chapter Seven investigates the general characteristics and the rationale of future policy studies, or of systematic forecasting as they are referred to in this research study, while Chapter Eight reviews a method often utilized in systematic forecasting, the Delphi technique.

Chapter Nine is devoted in its entirety to a recapitulation and summary of the Delphi technique exercise while Chapter Ten presents the conclusion and recommendations of the research study.

CHAPTER II

AN INTERDISCIPLINARY APPROACH TO POLITICS AND THE OLDER ADULT

The present research topic of politics and the older adult demands an interdisciplinary approach as many of the questions raised in this area are investigated by several of the behavioral sciences. Thus conceptual frameworks and findings from such fields as demography, psychology, sociology, economics, the health sciences, and of course, political science, relate directly or indirectly to the central topic being discussed here.

When an interdisciplinary approach is used, as in the present case, the first of two main principles of action that must be acknowledged is to be highly selective in the material to be chosen and presented from each of the areas in the interdisciplinary cluster. The selections must be continually tested against the thesis statement that the material chosen from the different disciplines explicates or helps to explicate the political activities of the older adults.

The second principle that should be acknowledged, when utilizing an interdisciplinary format, is that there is often considerable overlap among the various disciplines on the same issue. Several of the behavioral sciences may, and frequently do, involve themselves in the same area of investigation, each, of course, from a slightly different point of view. Rather than being conceived of as negative, this is, in fact, a very strong positive element in a study of this type. It is perhaps one of the main reasons for approaching the present study utilizing the interdisciplinary format.

With these two principles of action firmly in mind, the material from the various disciplines that relates to the problem at hand will be presented in the following order: demography, psychology, sociology, economics, and the health and political sciences.

Demography and the Older Adult

Demography may be described as the methods used to study human populations, with reference to size, distribution and vital statistics. Consequently, the topics that follow will be discussed in the following order: demographic methods, population size, geographical population distribution and population vital statistics.

Demographic Methods

The United States is frequently said to have an "aging population"; and at other times it is said to have an "old population." The first effort in the demography of aging must clarify these two observations. What does it mean to say that a population is getting "older" or "aging," and what does it mean to say that it is already "old"?

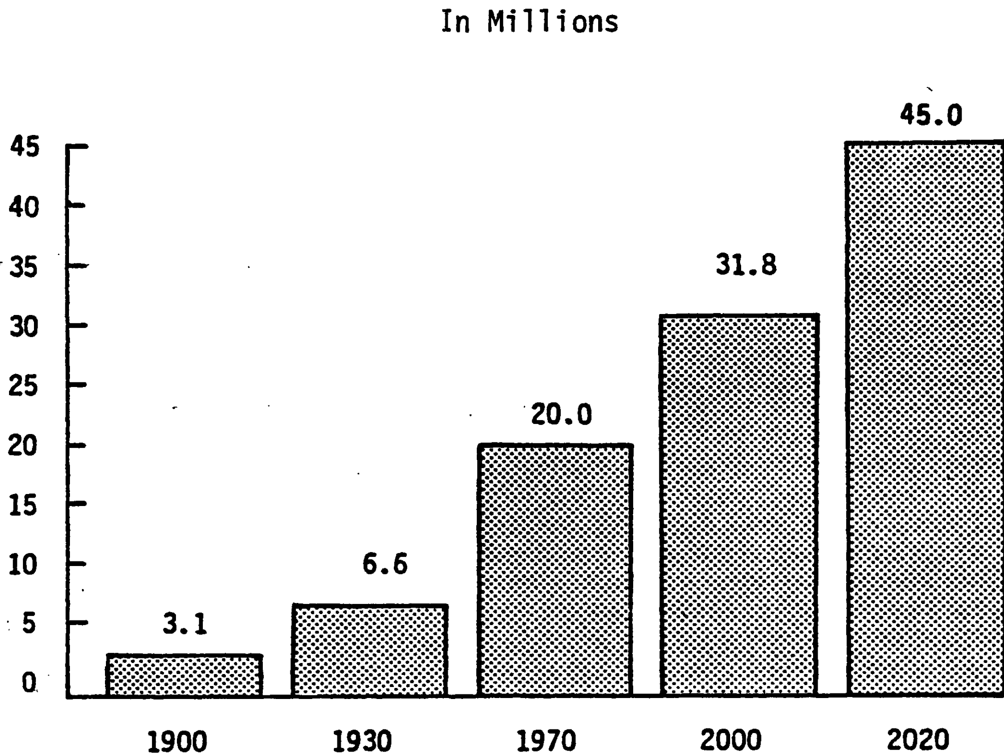
There are three main methods in particular that can be utilized to help define an "aging population." All three methods establish the basis for calculating long-term trend lines; and where this trend line is in an upward direction, the population is said to be "aging." These three techniques are the population age structure method, the age-dependent population method, and the index of aging method. Each of these demographic techniques is discussed below.

The Population Age Structure Method. The first method, the population age structure method, simply computes the number of persons 65 years and older in a specific population. This is then expressed as a percentage of proportion of the total demographic figures for that population group (Hendricks & Hendricks, 1981:58). The population age structure method is the most used of the three methods discussed in this section. Quite frequently these data are presented in the form of a chart or graph (see Figures 1, 2, 3).

The population age structure method produces a "percentage of total" population for the 65-years-and-older group. The United Nations (Hendricks & Hendricks, 1981:4) has developed a model, referred to here as the United Nations Demographic Model, which then categorizes the percentages of older persons in a nation's population and labels the nation as having a young, mature, or old population according to the following criteria:

1. A nation has a young population when persons 65 years and older constitute 4 percent or less of the total population.
2. A nation has a mature population when persons 65 years and older constitute between 5 through 7 percent of the total population.
3. A nation has an old population when persons 65 years and older constitute over 7 percent of the total population.

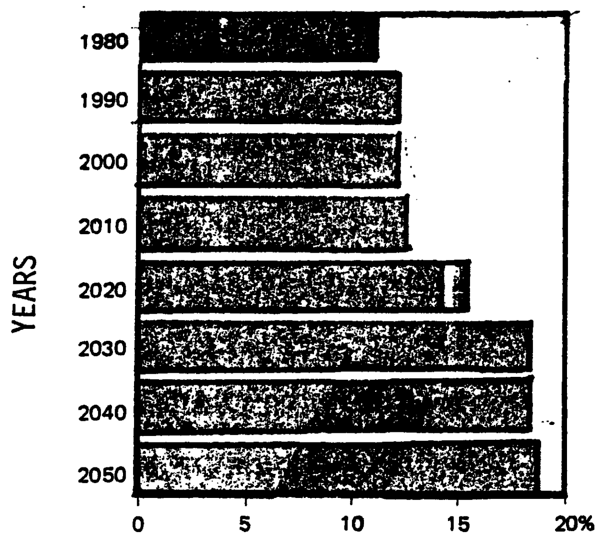
Based on the United Nation's Demographic Model, most Third World countries have young populations, most Eastern European countries have mature populations, and most Western industrialized nations, including the United States, have old populations. The advanced



Source: "Future Directions for Aging Policy: A Human Service Model." Sub-Committee of Human Services, Committee Publication No. 96-226. Washington, D.C.: U. S. Government Printing Office, p. 10.

Figure 1

GROWTH OF THE OLDER POPULATION IN THE TWENTIETH CENTURY

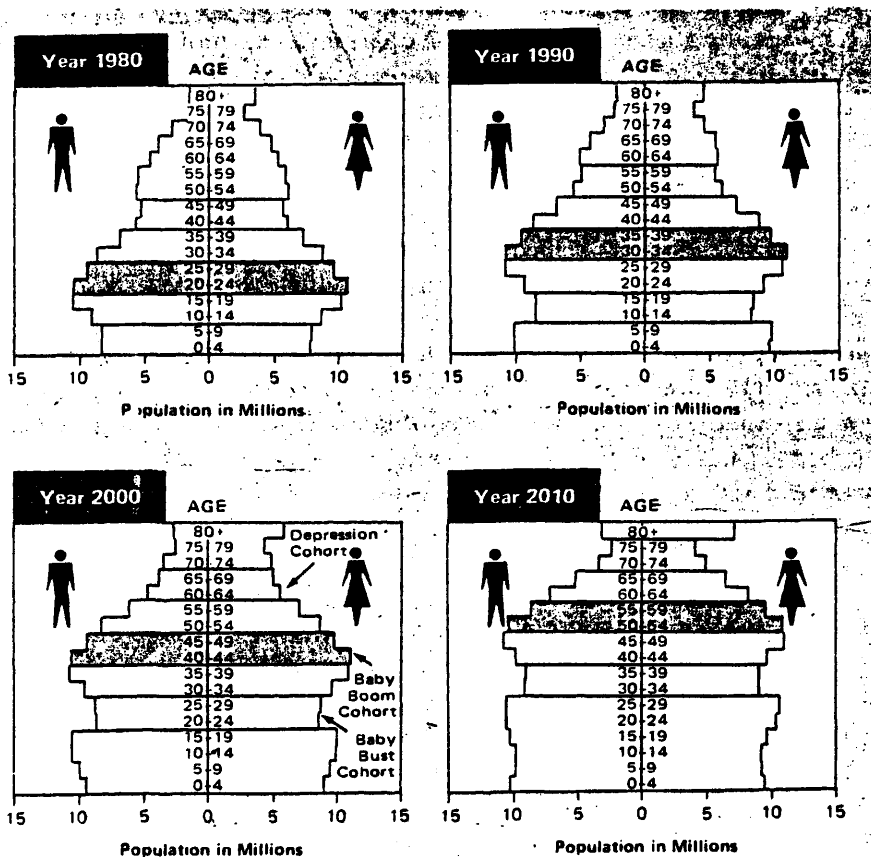


Percent of Total U.S. Population

Source: "America's Baby Boom Generation," Population Bulletin, 35 (April, 1980):29.

Figure 2

PROJECTED PROPORTION OF PERSONS AGE 65 AND OVER: 1980 THROUGH 2050



Source: Adapted from "America's Baby Boom Generation: The Fateful Bulge", Population Bulletin 35 (1980): 18.

Figure 3

PROGRESS OF DEPRESSION COHORT, BABY BOOM COHORT, AND BABY BUST COHORT

technology of the Western industrialized countries usually results in a drastic reduction in birth rates, while at the same time it appreciably extends the life expectancies of most of the present citizenry, thus producing what is referred to as an "old population," utilizing the terminology of the United Nation's Demographic Model.

The Age-Dependent Population Method. This method combines the number of persons over 65 years of age with the total number of children under 15 years of age and then compares this grand total to the number of persons between the ages of 14 and 65 (Hendricks & Hendricks, 1981:61). This produces a very rough estimate of the working population versus the dependent or nonworking population. This method does have a number of limitations. It is readily apparent that not all persons in the first group may be unemployed, while not all persons in the second group may be employed; however, in an approximate manner, it does convey a holistic picture in a highly cryptic fashion, which may be quite useful at times.

The Index of Aging. This method first identifies the number of persons 65 years of age and older and the number of persons 15 years of age and younger. Rather than combining them into a composite group and then comparing them to a third set of figures, it compares these two sets of figures directly to each other. This establishes an index for an analysis involving population dynamics (Hendricks & Hendricks, 1981:61). Thus the proportion of young citizens are compared to the proportion of old citizens of a particular country.

In summary, all three of these demographic methods--the age structure method, the age-dependent population method, and the index

of aging method--when applied to the population data of the United States, produce results that are labeled as "aging population figures." This is because the long-term trend line is upwardly inclined until the year 2050 in these forecasted data sets. Thus is can be said at this point that the United States has both an "aging population" and an "old population," depending on the model or method used to arrive at the analysis.

Population Size

The widely circulated publication, prepared for presentation to the members of the U. S. Congress in 1980 by the Subcommittee of Human Services under the direction of Congressman Mario Biaggi and formally entitled "Future Directions for Aging Policy: A Human Service Model" (1980), states:

> In 1900 there were about 3 million Americans, age 65 plus, in the U.S. By 1940 the number had trebled to 9 million, and in the most recent census of 1970, 20 million persons, age 65 or over, were counted. Today that number stands at about 24 million; it is expected to reach 31 million by the year 2000. Twenty years later there may well be 45 million older Americans in America.

Converting sheer numbers into percentages of increases, the proportion of the population 65 and older in the United States is forecasted to increase from the present through the year 2040. Three demographic projections for these years are presented in Table 1. This increase in the proportion of the population in the age group that is 65 years of age and older reflects two things. First, it reflects a decrease in the crude birth rates; second, it reflects an increase in the life expectancy of those who were born

TABLE 1

ESTIMATES AND PROJECTIONS OF THE POPULATION 65 YEARS AND OVER: 1975 TO 2040
(Populations in thousands. As of July 1)

Year	Population 65 years and over				
	Number	Percent change in preceding 5 years	Percent of total population		
			Series I	Series II	Series III
ESTIMATES					
1975	22,405	...	10.5		
1976	22,934	...	10.7		
PROJECTIONS					
1980	24,927	+11.3	11.1	11.2	11.3
1985	27,305	+9.5	11.4	11.7	11.9
1990	29,824	+9.2	11.7	12.2	12.6
1995	31,401	+5.3	11.7	12.4	13.0
2000	31,822	+1.3	11.3	12.2	12.9
2005	32,436	+1.9	10.9	12.1	13.0
2010	34,837	+7.4	11.1	12.7	13.9
2015	39,519	+13.4	11.8	14.0	15.6
2020	45,102	+14.1	12.7	15.5	17.8
2025	50,920	+12.9	13.6	17.2	20.2
2030	55,024	+8.1	14.0	18.3	22.1
2035	55,805	+1.4	13.5	18.3	22.7
2040	54,925	-1.6	12.5	17.8	22.8

Source: "Future Directions for Aging Policy: A Human Services Model." Subcommittee on Human Services, Committee Publication No. 96-226. Washington, D.C.: U. S. Government Printing Office, p. 1.

more recently. Generally ". . . individuals [can] expect to live 20 years longer if they were born in 1960 rather than in 1900" (Hendricks & Hendricks, 1981:57).

It is true, at present, the citizens of the United States have a rather long life expectancy--69.3 years for men and 77.1 years for women. However, the citizens of Iceland, Japan, Denmark, the Netherlands, Norway and Sweden, all have longer life expectancies than do the citizens of the United States (see Table 2).

Geographic Population Distribution

Persons 65 years and older are spread unevenly among the 50 states. According to the study entitled "Future Directions for Aging Policy" (1980) which was cited earlier in this research study:

> California and New York, each with more than 2 million older people, accounted for almost 4.3 million or 1 in 5 of the older people of the United States in 1977. Six additional states (Florida, Pennsylvania, Texas, Illinois, Ohio and Michigan), with almost 7.3 million older people, brought the eight state total to 11.5 million or almost half of the nation's elderly.
>
> The most rapid growth (the largest percentage increases) in 1960-70 occurred in Arizona (79 percent), Florida (78.2), Nevada (70.4), Hawaii (51.3) and New Mexico (37.7), all states with a large number of immigrants. These five states also had the fastest growth rates in 1970-77. Florida still has the highest proportion of older people--17.1 percent in 1977 (14.5 in 1970). Alaska, with just over 2 percent, remains the state with the smallest number and smallest proportion of older persons (9,000 or 2.2 percent in 1977).

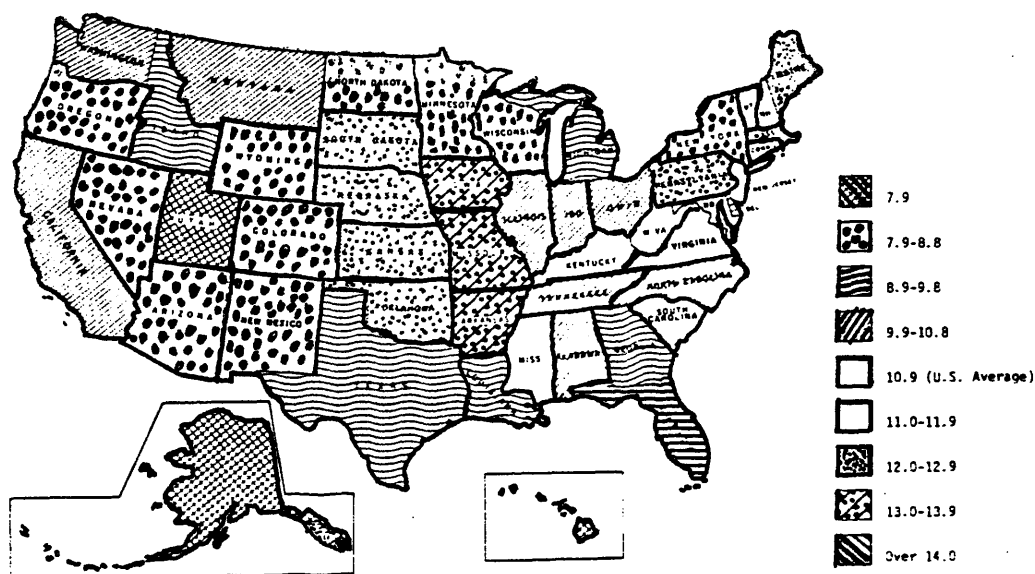
Another way of approaching the subject of geographical population distribution is graphically. In this manner, a total representation of the proportion of older adults in each of the states can be presented in a highly concise and efficient manner (see Figure 4).

TABLE 2

LIFE EXPECTANCY AT BIRTH FOR SELECTED COUNTRIES

Date	*Country*	*Years*	
		Male	*Female*
1976	Austria	68.1	75.1
1972	Canada	69.3	76.4
1975	China	59.9	63.3
1976	Denmark	71.1	76.8
1975	Finland	67.4	75.9
1974	France	69.0	76.9
1976	Fed. Rep. Germany	68.3	74.8
1970	German Democ. Repub.	68.8	74.2
1976	Iceland	73.0	79.2
1975	Israel	70.3	73.9
1976	Japan	72.2	77.4
1975	Netherlands	71.2	77.2
1976	Norway	71.8	78.1
1976	Sweden	72.1	77.7
1972	U.S.S.R	64.0	74.0
1976	U.K.: England and Wales	69.6	75.8
1977	U.S.A.	69.3	77.1

Source: United Nations, Demographic Yearbook, 1977, 29th ed. New York: United Nations, 1978, pp. 442-463.



Source: "Future Directions for Aging Policy: A Human Service Model." Subcommittee on Human Services, Committee Publication No. 96-226. Washington, D.C.: U. S. Government Printing Office, p. 117.

Figure 4

PERCENT OF EACH STATE'S POPULATION AGED 65 AND OLDER, 1977

As far as the urban-suburban dichotomy is concerned, a higher percentage of younger people live in urban areas (68%) as opposed to older people (63%). Of course, the term "urban" can be defined in different ways; however, approximately half of the older adults reside in the central business districts with approximately the same percentage of the under 65, living in the suburbs (Future Directions, 1980:117). Within the next 20 years, however, these figures will be drastically altered. The process known as the "greying-in-place" of the suburbs will occur. That is, the younger people who transferred to the suburbs in such mass flight following World War II will begin to move into the elderly age group in the 1980's if, in fact, they did not join this age group in the 1970's.

Population Vital Statistics

In addition to calculating the total population figures for the 65-years-and-older population, demography is interested in the various characteristics of the different cohorts making up such a population. For example, Skrabanek, Upham & Dickerson (1975:9) state:

> One of the main reasons almost every public document asks for an individual's age and sex is that these factors are relevant to most circumstances involving a human being. In general, people of different ages and of different sex have different interests and capabilities for performing the many and diverse roles and activities in society. It becomes important, therefore, to review the changing age and sex composition of the older population.

It is not only the purpose of this section to review both the changing age and sex composition of the older population in the United States, but also to review the changing patterns of the different cohorts in reference to age and educational attainment. These areas

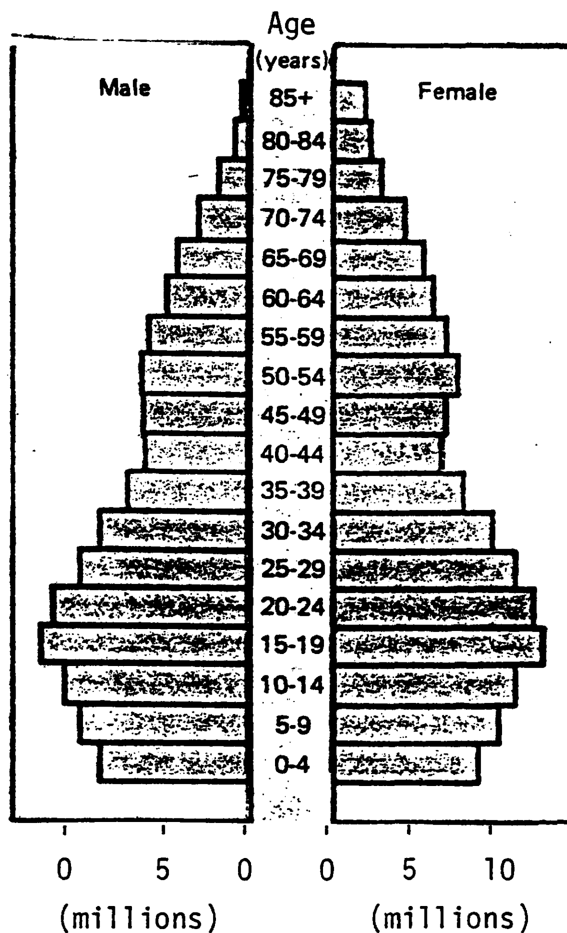
of vital statistics are considered to be most germane to the issue of the older adult as a political actor.

Age and Sex Composition

As the life cycle of aging continues, there are progressively more women in the more advanced aging cohorts. This can most readily be seen, perhaps, in an age-sex profile chart (see Figures 5 and 6) based on the Bureau of the Census data.

Brotman (Brotman, 1979:359-361) presents three tabular presentations, using data also from the Bureau of the Census. These include estimates for 1975 and projections for the year 2000. These data are exceptionally well arranged for easy reading considering the variety of dimensions represented in the tables. Of particular interest here is not only the ratio of men to women as the age ranges increase but also the increase in the percentage of persons occupying the more advanced age ranges between the two periods being compared--the years 1975 and 2000.

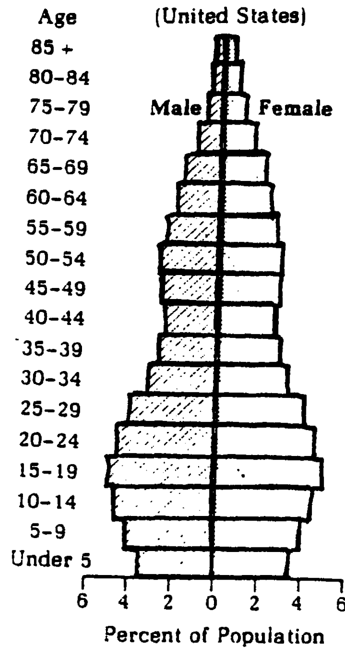
From the Brotman (Brotman, 1979:357-395) tables (Tables 3, 4, and 5) it can be seen that for all races in 1975 there were 144 women for every 100 men and that it is projected that by the year 2000 there will be 154 women for every 100 men. The social implications of this data are very important. There would be a large number of older widows in the United States even if it were not the social practice of men to marry younger women; however, this practice amplifies still further an already quite serious problem. In fact, Palmore (Palmore, 1980:436) points out that:



Source: Adapted from Population Profile of the United States: 1978. U. S. Department of Commerce, P-20, 336 (April 1979): front cover.

Figure 5

AGE-SEX COMPOSITION IN THE UNITED STATES IN PERCENTAGES



Source: Adapted from A. Hauyst and T. Kane Population Handbook. Population Reference Bureau, Inc., 1978, p. 4.

Figure 6

ANALYSIS OF OLDER POPULATION PROJECTIONS BY SEX AND RACE, 1976, ALL RACES

TABLE 3

ANALYSIS AND PROJECTIONS OF OLDER POPULATION BY SEX AND RACE, 1976 & 2000

(Numbers in thousands). ALL RACES

AGE	TOTAL #	TOTAL %		MEN #	MEN %		WOMEN #	WOMEN %		PER 100 MEN
1975										
55+	42,099	100.0	—	18,483	100.0	—	23,616	100.0	—	128
65+	22,330	53.0	100.0	9,147	49.5	100.0	13,182	55.8	100.0	144
55–59	10,531	25.0	—	5,020	27.2	—	5,511	23.3	—	110
60–64	9,238	21.9	—	4,316	23.4	—	4,923	20.9	—	114
65–69	8,097	19.2	36.3	3,581	19.4	39.2	4,515	19.1	34.3	126
70–74	5,784	13.7	25.9	2,446	13.2	26.7	3,337	14.1	25.3	136
75–79	3,998	9.5	17.9	1,570	8.5	17.2	2,428	10.3	18.4	155
80–84	2,629	6.2	11.8	953	5.2	10.4	1,675	7.1	12.7	176
85+	1,822	4.3	8.2	596	3.2	6.5	1,226	5.2	9.3	206
55–64	19,769	47.0	—	9,336	50.5	—	10,434	44.2	—	112
65–74	13,881	33.0	62.2	6,027	32.6	65.9	7,852	33.2	59.6	130
75+	8,449	20.0	37.8	3,119	16.9	34.1	5,329	22.6	40.4	171
2000										
55+	53,537	100.0	—	22,953	100.0	—	30,583	100.0	—	133
65+	30,600	57.2	100.0	12,041	52.5	100.0	18,558	60.7	100.0	154
55–59	12,947	24.2	—	6,224	27.1	—	6,723	22.0	—	108
60–64	9,990	18.7	—	4,688	20.4	—	5,302	17.3	—	113
65–69	9,023	16.9	29.5	4,021	17.5	33.4	5,002	16.4	27.0	124
70–74	8,056	15.1	26.3	3,368	14.7	28.0	4,688	15.3	25.3	139
75–79	6,224	11.6	20.3	2,375	10.4	19.7	3,849	12.6	20.7	162
80–84	4,080	7.6	13.3	1,383	6.0	11.5	2,697	8.8	14.5	195
85+	3,217	6.0	10.5	894	3.9	7.4	2,323	7.6	12.5	260
55–64	22,937	42.8	—	10,912	47.5	—	12,025	39.3	—	110
65–74	17,079	31.9	55.8	7,389	32.2	61.4	9,690	31.7	52.2	131
75+	13,521	25.3	44.2	4,652	20.3	38.6	8,868	29.0	47.8	191
% increases										
55+	27.2			24.2			29.5			
65+	37.0			31.6			40.8			
55–59	22.9			24.0			22.0			
60–64	8.1			8.6			7.7			
65–69	11.4			12.3			10.8			
70–74	39.3			37.7			40.5			
75–79	55.7			51.3			58.5			
80–84	55.2			45.1			61.0			
85+	76.6			50.0			89.5			
55–64	16.0			16.9			15.2			
65–74	23.0			22.6			23.4			
75+	60.0			49.2			66.4			

Source: H. B. Brotman, "Population Projections: Tomorrow's Older Population (to 2000)." J. Hendricks and C. D. Hendricks (Eds.), Dimensions of Aging. Cambridge, Mass.: Winthrop Publishers, Inc., 1979, p. 357.

TABLE 4

ANALYSIS AND PROJECTIONS OF OLDER POPULATION BY SEX AND RACE, 1978 & 2000

(Numbers in thousands). WHITE

AGE	TOTAL #	TOTAL %	TOTAL %	MEN #	MEN %	MEN %	WOMEN #	WOMEN %	WOMEN %	PER 100 MEN
1975										
55+	38,185	100.0	—	16,735	100.0	—	21,450	100.0	—	128
65+	20,317	53.2	100.0	8,278	49.5	100.0	12,039	56.1	100.0	145
55–59	9,521	24.9	—	4,551	27.2	—	4,970	23.2	—	109
60–64	8,347	21.9	—	3,906	23.3	—	4,441	20.7	—	114
65–69	7,267	19.0	35.8	3,217	19.2	38.9	4,050	18.9	33.6	126
70–74	5,298	13.9	26.1	2,225	13.3	26.9	3,073	14.3	25.5	138
75–79	3,578	9.6	18.1	1,431	8.6	17.3	2,246	10.5	18.7	157
80–84	2,418	6.3	11.9	870	5.2	10.5	1,548	7.2	12.9	178
85+	1,657	4.3	8.2	535	3.2	6.5	1,122	5.2	9.3	210
55–64	17,868	46.8	—	8,457	50.5	—	9,411	43.9	—	111
65–74	12,565	32.9	61.8	5,442	32.5	65.7	7,123	33.2	59.2	131
75+	7,753	20.3	38.2	2,536	17.0	34.3	4,916	22.9	40.8	173
2000										
55+	47,101	100.0	—	20,218	100.0	—	26,883	100.0	—	133
65+	27,113	57.6	100.0	10,638	52.6	100.0	16,475	61.3	100.0	155
55–59	11,294	24.0	—	5,472	27.1	—	5,821	21.7	—	106
60–64	8,694	18.5	—	4,108	20.3	—	4,587	17.1	—	112
65–69	7,777	16.5	28.7	3,489	17.3	32.8	4,287	16.0	26.0	123
70–74	7,144	15.2	26.4	2,985	14.8	28.1	4,159	15.5	25.2	139
75–79	5,611	11.9	20.7	2,132	10.6	20.0	3,479	12.9	21.1	163
80–84	3,687	7.8	13.6	1,240	6.1	11.7	2,447	9.1	14.9	197
85+	2,894	6.1	10.7	791	3.9	7.4	2,103	7.8	12.8	266
55–64	19,988	42.4	—	9,580	47.4	—	10,408	38.7	—	109
65–74	14,921	31.7	55.0	6,474	32.0	60.9	8,446	31.4	51.3	130
75+	12,192	25.9	45.0	4,163	20.6	39.1	8,029	29.9	48.7	193
% increases										
55+	23.3			20.8			25.3			
65+	33.5			28.5			36.9			
55–59	18.6			20.2			17.1			
60–64	4.2			5.2			3.3			
65–69	7.0			8.5			5.9			
70–74	34.8			34.2			35.3			
75–79	52.6			49.0			54.9			
80–84	52.5			42.5			58.1			
85+	74.7			47.9			87.4			
55–64	11.9			13.3			10.6			
65–74	18.8			19.0			18.6			
75+	57.3			46.8			63.3			

Source: H. B. Brotman, "Population Projections: Tomorrow's Older Population (to 2000)." J. Hendricks and C. D. Hendricks (Eds.), Dimensions of Aging: Readings. Cambridge, Mass.: Winthrop Publishers, Inc., 1979, p. 358.

TABLE 5

ANALYSIS AND PROJECTIONS OF OLDER POPULATIONS BY SEX AND RACE, 1978 & 2000

(Numbers in thousands). BLACK

	TOTAL			MEN			WOMEN			PER 100 MEN
AGE	#	%		#	%		#	%		
1975										
55+	3.525	100.0	—	1.547	100.0	—	1.978	100.0	—	128
65+	1.803	51.2	100.0	761	49.2	100.0	1.044	52.8	100.0	137
55–59	908	25.8	—	419	27.1	—	489	24.7	—	117
60–64	812	23.0	—	387	23.7	—	445	22.5	—	121
65–69	768	21.8	42.6	329	21.3	43.2	439	22.2	42.1	133
70–74	428	12.1	23.7	191	12.4	25.1	237	12.0	22.7	124
75–79	276	7.8	15.3	118	7.6	15.5	159	8.0	15.2	135
80–84	188	5.3	10.4	73	4.7	9.6	115	5.6	11.0	158
85+	144	4.1	8.0	50	3.2	6.6	94	4.8	9.0	188
55–65	1.720	48.8	—	786	50.8	—	934	47.2	—	119
65–74	1.196	33.9	66.3	520	33.6	68.3	676	34.2	64.8	130
75+	608	17.3	33.7	241	15.6	31.7	368	18.6	35.2	153
2000										
55+	5.335	100.0	—	2.290	100.0	—	3.046	100.0	—	133
65+	2.942	55.2	100.0	1.188	51.9	100.0	1.753	57.6	100.0	148
55–59	1.323	24.8	—	617	26.9	—	707	23.2	—	115
60–64	1.070	20.1	—	485	21.2	—	586	19.2	—	121
65–69	1.075	20.2	36.5	460	20.1	38.7	615	20.2	35.1	134
70–74	775	14.5	26.3	331	14.5	27.9	445	14.6	25.4	134
75–79	505	9.5	17.2	204	8.9	17.2	301	9.9	17.2	148
80–84	326	6.1	11.1	117	5.1	9.9	209	6.9	11.9	179
85+	260	4.9	8.8	76	3.3	6.4	184	6.0	10.5	242
55–64	2.393	44.8	—	1.102	48.1	—	1.293	42.4	—	117
65–74	1.850	34.7	62.9	791	34.5	66.6	1.060	34.8	60.5	134
75+	1.091	20.5	37.1	397	17.3	33.4	694	22.8	39.6	175
% increases										
55+	51.4			48.0			54.0			
65+	63.0			56.1			67.9			
55–59	45.7			47.3			44.6			
60–64	31.8			32.2			31.7			
65–69	40.0			39.8			40.1			
70–74	81.1			73.3			87.8			
75–79	83.0			72.9			89.3			
80–84	73.4			60.3			81.7			
85+	80.6			52.0			95.7			
55–64	39.1			40.2			38.4			
65–74	54.7			52.1			56.8			
75+	79.4			64.7			88.6			

Source: H. B. Brotman, "Population Projections: Tomorrow's Older Population (to 2000). Dimensions of Aging: Readings, J. Hendricks and C. D. Hendricks (Eds.). Cambridge, Mass.: Winthrop Publishers, Inc., 1979, p. 359.

> There are three unmarried women over 65 for each unmarried man, so even if every unmarried man over 65 married a woman over 65, two-thirds of the unmarried women would remain unmarried.

Interestingly enough, the proportions of older adults of all races in the age ranges over 75 (i.e., 75-79, 80-84 and 85+) are forecasted to increase much faster than are the proportions in the lower age ranges. The proportion of older white adults in the 75-79 category, the 80-84 category and the 85+ category are forecasted to increase 52.6, 52.5, and 74.7 percent, respecitvely. The proportion of older black adults in these same categories are forecasted to increase 83.0, 73.4, and 80.6 percent, respectively. Of course, women in both the white and black categories and in all of the age ranges of older adulthood are projected to increase at faster rates than men in the comparable age ranges (Brotman, 1979:358-359).

Age and Schooling

Of the present 65-and-older population, 47 percent have not completed one year of high school. The scale is fairly evenly balanced at both ends for the members of this age group--about 8 percent are college graduates and about 8 percent are functional illiterates who have less than five years of schooling (Current Population Report, 1980:1).

Using 1980 U. S. Census data (Current Population, 1980:1-5), a detailed comparison can be made of educational attainment of all groups 14 years and older through 75 years and older. The data are divided at five-year intervals for easy comparison among age groups.

The data here are comprehensive, covering the various ethnic groups--the white, the black, and the Hispanics (see Appendix I).

Although official data for school completion are very important to a study of this type, a briefer summary of the data related to school completion by the older adults is also useful. Hess and Markson (1980:300) indicate in a summary format, using data from 1930 through 2000, that, on the average a large percentage of persons 60-64 years of age has greatly increased their years of schooling and that this type of increase should continue through the year 2000, which is the last time period referenced in the Table (see Table 6).

Actually, this rise in education for the older population has great significance with regard to trends in political activities for the 65 and older population group. This issue will be investigated in the section in this research study devoted to political science and the older adult.

Psychology and the Older Adult

The later stages of the human life cycle have occupied the interest of psychologists only relatively recently. Presently, there is much work being done in this field. As the focus of this research study is on politics and the older adult, the supporting topics that must receive some rather close attention in this section are related to the following issues: personality stability versus personality changeability in the later stages of the life cycle; the ability or the disability of persons to learn new concepts in the later stages of the life cycle; and the general question of mental

TABLE 6

PERCENTAGE DISTRIBUTION OF WHITE POPULATION AGED 60-64 BY YEARS OF SCHOOL COMPLETED: USA, 1930-2000

	White Males				White Females			
Year	0-7	8-H.S.3	H.S.4	Some College	0-7	8-H.S.4	H.S.4	Some College
1980								
1910								
1920								
1930	45.6	41.8	6.1	6.5	39.1	45.9	9.5	5.5
1940	41.3	43.0	7.8	8.0	35.6	45.8	11.5	7.1
1950	40.4	39.5	10.1	10.0	35.5	41.7	13.2	9.5
1960	32.8	43.4	11.2	12.6	28.7	43.5	15.3	12.5
1970	21.4	41.7	19.1	17.7	17.6	40.8	24.0	17.6
1980	12.5	35.1	30.5	21.8	10.2	34.9	37.4	17.5
1990	9.7	30.3	30.9	29.1	7.2	28.9	43.4	20.5
2000	6.4	22.3	37.7	33.6	5.3	23.4	46.9	24.4

Source: B. B. Hess and E. W. Narkson. Aging and Older Age: An Introduction to Social Gerontology. New York: Macmillan Publishing Co., Inc., 1980, p. 300.

flexibility or inflexibility of persons in the later stages of the life cycle. If for the large majority of older persons, personality development is considered to be relatively stable, if the large majority of older adults can still learn new things, and if older persons do not become inflexible in their mental processes, then there is the possibility that at least the psychological foundations exist for this group to coalesce into an effective political force under the proper conditions. If the answer to any or to all of these questions is negative, then the ability of this group to become an effective political force in the future is substantially reduced.

To provide a background for considering the three issues cited above, a brief review of what are perhaps the main theories of aging is presented here. The concepts of three theorists who accomplished important work prior to 1960 are first reviewed, followed by the presentation of three major theories of aging which generally become widely known during the period of the 1960's. Then there is a presentation of the work of the life-span theorist, the late Claus Reigel, which became widely known in the 1970's.

A brief section is devoted to methodology, as progress has been particularly swift in this area during the last ten years. Because theoretical concepts are influenced by the methodology involved as well as by the bias of the theoretician, the level of assessment utilized, and the type of measuring devices employed, it is necessary to look closely at methodology at this point in the research study.

The subjects of personality, learning and flexibility in elderly persons will then be investigated. The latest research

findings in these areas will be reviewed to permit a summary position to be taken on each issue.

Theory of Aging Prior to 1960

Three persons in particular stand out as having made contributions to the theory of aging prior to 1960. None of these theorists is, at least in the modern sense, primarily a theorist of aging; yet, each contributed new concepts to what later became known as the theory of aging. These theorists are Carl Jung and Eric Erickson, both ego psychologists, and Charlene Buhler.

Oddly enough, Jung and Erickson are both fairly well known for their work in aging theory although neither is much more than a footnote in the history of the theory of aging. Buhler, the least known of these three theorists, actually made the most notable contributions to the field (Hayslip, 1982:no page).

Jung. Jung's work in the area of "individuation" and "personal psychology" is clearly based on a conflict model. In this model, different aspects of an individual's personality are conceived as being in opposition to one another. The realignment of these opposing tendencies, according to Jung, could, under the right conditions, bring about the ideal state of self-actualization in the individual. In fact, Jung uses the term "static tension" to refer to such a process. This process is the key to Jung's concept of aging psychology--a continuing process of self-actualization in old age (Jung, 1971:55-87).

Erickson. Erickson considers the life span of the individual. This is not to be confused with the conceptualized model called "life span psychology" which is to be discussed later in this section. The theory developed by Erickson involves an eight-stage theoretical model. Growth and change occur in one stage only if the prerequisite growth and change have occurred in the previous stage. The life span of an individual theoretically permits the development of the individual through all eight stages of this life cycle. Of course, not all people manage to reach the later stages described in the model developed by Erickson, while others reach these later stages and fall back to behaviors defined as appropriate to earlier stages in the model (Erickson, 1963; 1968).

The last three crises of this stage theory--intimacy versus isolation, generativity versus stagnation, and integrity versus despair--are the stages covered by the period of adult life. In reference to these three stages, Clayton (1975:120) remarks:

> The question remains if the individual is ever ready to face the last three major life crises, or if he is ever prepared to reach them. While Erickson's theory of development is appropriate in its description of and application to childhood crises and their resolutions (perhaps because it parallels Freud's psychosexual stages), little or no examination has been made of the crises and their resolutions as they apply to the later stages of individual development. Few researchers have attempted careful analyses of the concurrent changes within the adult individual and within his milieu to see if such resolutions of the crises emerge or even have the possibility of emerging.

Buhler. Buhler was the first theorist to differentiate clearly the aging process of older adults from the other developmental periods of life. The Buhler model of aging has three phases. These

three phases are identified by the exceedingly succinct labels of Adult I, Adult II, and Aged (Buhler, 1968:55-78).

Buhler stressed life events, and the way these events are interpreted by the person living the life being examined, which she calls biographical events. In fact, it was Buhler who instituted the process referred to as "life review" or "life biography," a process used to help bring about, in certain client situations, an inner order, thus helping to achieve a feeling of self-fulfillment on the part of the individual concerned.

Buhler's theory of aging, usually referred to as the Life Tendencies Model, rests directly on the following five processes:

1. The life tendency to require basic needs satisfaction.
2. The life tendency to require adaptation within "self-limitations."
3. The life tendency to require creative expansion.
4. The life tendency to require the establishment of an inner order.
5. The life tendency to require self-fulfillment (Hayslip, 1982:no page).

Aging Theory During the 1960's

The three theories of aging that perhaps had the greatest impact on the decade of the 1960's were the disengagement theory, the activity theory, and the continuity theory. The disengagement theory "is sociological in character, with most of the research . . . being carried out by sociologists, [however,] there is corroborating

evidence from various psychological investigations" (Botwinick, 1978:61). In addition, both activity theory and continuity theory are also partly sociological in character. Consequently, all three of these aging theories will be briefly discussed here in the section on psychology and the older adult and then, from a somewhat different point of view in the section devoted to sociology and the older adult.

The ordering of these three aging theories of aging--disengagement, activity, and continuity theory--deserves a word of note. In actuality, activity theory was formulated first. Bell (1976:31) states:

> Largely through the efforts of Havighurst and Albrecht (1953) and Cavan et al. (1949), the activity theory began to emerge as an attempt not only to integrate much previously accumulated knowledge, but also to explain a number of empirically based findings.

The activity theory was essentially in place as a theory in the early 1950's. The issue here was more than anything else a problem of public need and acceptance at the time the theory was originally introduced.

The data upon which the disengagement theory is based were gathered in the last half of the 1950's as part of the famous Kansas City Study of Adult Life. Based on this data, Cumming and Henry (1961), set forth a formal theoretical position which they called the disengagement theory. Suddenly, as part of the battle cry against the disengagement theory, the activity theory was immediately pressed into good service. Consequently, when these two theories--the disengagement theory and the activity theory--

are presented in the professional literature, the older theory is usually placed second. This tradition will be observed in this section, as well. These two theories will be followed by a short review of the theoretical concept called the continuity theory of aging.

Disengagement Theory. Cumming and Henry (1961) formulated the disengagement theory as a theory of mutual withdrawal and decreased interactions between older adults and the society at large. There has been a trend in the research efforts related to disengagement theory to be concerned primarily with the immediate personal interactions of older adults. Too, there is a tendency to generalize these trends to all older adults. Both of these characteristics will be more closely examined below.

Activity Theory. While Havighurst and Albrecht (1953) are the primary seminal theorist for activity theory, the theory has attracted a wide range of first-rate theorists who have made notable contributions to the field. Thus activity theory is no longer closely linked to the work of any one theorist in the way, for example, that disengagement theory is linked to Cumming and Henry.

The essence of the activity theory is that there exists a positive correlation between the activity of an older adult and the degree of life satisfaction that will be experienced by this individual. As activity decreases so does life satisfaction (Lemon, Bengston & Peterson, 1976:51).

Continuity Theory. Among continuity theorists, perhaps the best known is Bernice Neugarten. The continuity theory of aging is based on the premise that there is continuity, over the life cycle, in a person's life style. Stability and change in life style are, of course, both possibilities but not for the same trait, in the same person, and at the same time. According to Neugarten, the three main factors determining stability and change in a person's life style are:

1. Personality type
2. Extent person is engaged or disengaged
3. Extent to which person is "life satisfied" (Kimmel, 1980: 405-408).

Theory of Aging in the 1970's.

Life-span theory, which received considerable attention in the 1970's, permits a decidedly new approach to the theory of aging. Life-span theory is also perhaps the most psychological theory of aging discussed thus far.

Life-span theory is based on a radical departure from traditional theorizing in the area of aging. For example, Schaie and Willis (1978:8-9) state:

> . . . [the] researcher interested in life span conceptualizations will need to step away from a concept of development which is synonymous with the notion of growth as differentiation. The latter concept assumes that as each new developmental plateau is reached, further development occurs through the emergence of more complex strucutures. For example, in the area of intellectual development it has been proposed that children do indeed start out with a unitary single-factor component, but as growth occurs

> it consecutively branches into a number of separate abilities organized in a hierarchical manner. In adulthood this kind of differentiation is likely to cease and transformations will be of a more qualitative nature in response to environmental presses. In old age there may in fact once again be a return to greater simplicity of structure, if only to counteract information overload.

Life-span theory stresses a developmental process that possesses multidimensionality, multidirectionality and multiintensiveness. Many changes are going on in the older adult at the same period of time; some are increases and some are decreases; some involve a considerable degree of change and others involve only a mild degree of change.

The conceptualizations of life-span theory relegate to the "trashbins of history" such traditional approaches to aging as the irreversible decrement model, the stability model, the decrement-with-compensation model, or the age-as-dependent-variable model (Schaie & Willis, 1978:10). With the life-span concept, the aging cycle cannot be presented as a time of change that stresses the universal and irreversible decline of old age because at any point in time any one person is experiencing a multidimensional, multidirectional change process that involves a series of changes at various levels of intensity.

One of the better known life-span psychologists is the late Claus Reigel. In 1975 he developed a conceptual framework for life-span psychology, which is referred to as the "Reigel Dialectics Model of Life-Span Development," hereafter referred to in this research study as simply the Reigel model. Although Reigel died shortly after developing this conceptual model, Datan and Reese (1980) have been carrying on this work.

The Reigel model (Reigel, 1976) is based on the basic premise of change as opposed to, say, Erickson's model (Erickson, 1968), among others, which is based on the basic premise of stability. In fact, the concepts of multidimensionality and multidirectionality appear as basic premises of the model developed by Reigel.

The Reigel model is deceptively simple and "elegant" in research terminology, but the range and depth of its application make it a powerful and "fertile" model. The main "categories" of the model are an inner and an outer dialectical event. These two "categories" are then divided into two "subcategories": for the inner dialectic, (a) the individual psychology and (b) the inner biology; for the outer dialectic, (a) the cultural-sociological and (b) the outer physical (Kimmel, 1980:18).

The Reigel model directs the attention of the researcher in basically four major directions at once. This is necessary because the model is both multidimensional and multidirectional. Frequently, several things happen simultaneously to an aging person. The emphasis here is on change, not just decline or decremental change, but on all of the important changes the aging person is experiencing. Change is considered to be a constant factor in all of life's processes.

New Methodological Approaches in Aging Theory for the 1970's

Historically, in studying older people, one of two research methods were used: the cross-sectional or longitudinal approaches. Schaie and Willis (1978:12) state:

The former method therefore confounds ontogenetic change with generational differences, while the latter confounds ontogenetic change with the effects of sociocultural change occurring between times of measurement (or what the sociologists call period effects). For most behavioral variables these confounds are bound to be large, and it is unlikely that findings of cross-sectional age differences will agree with those obtained from longitudinal age changes.

A series of "sequential designs" have been developed as alternates to the traditional cross-sectional and longitudinal strategies. Schaie and Willis (1978:13-14) succinctly review this rather complex material as follows:

> The researcher interested in age changes wishes to find functions which describe ontogenetic changes across the life course and must therefore demonstrate that such functions do not simply describe the impact of specific historic events on a single birth cohort. In this instance the same age range should be monitored for two or more successive cohorts, using a design we have called the cohort-sequential method. In this manner it is possible to segregate the effect on intraindividual ontogenetic variance from interindividual generational difference variance.
>
> Researchers studying age differences frequently want to obtain information on the question of whether there are generational differences which account for behavior difference between the young and old at a particular point in time. In this case, however, we need to know whether such differences remain stable or are an artifact of particular age-cohort combinations occurring at a single measurement point. This is best accomplished by use of the time-sequential design, which involves two or more replications of the age range covered by a specific cross-sectional study.
>
> Finally, we should note that many developmentally oriented investigators are not really interested in aging per se. What they want to know is whether there are stable generational differences or sociocultural changes which may determine behavior change over time. This argues for the cross-sequential method in which two or more cohorts are samples at two or more measurement points in order to differentiate between the effects of differential early life experience or other generation-specific variance and period effects introduced by sociocultural change.

In considering the sequential designs, it is important to remember that every research method is built on certain assumptions of the person or persons developing the method under consideration. For example, both the more traditional longitudinal method and the newer cohort-sequential methods assume that the effects of the time period involved, called the period effects, are trivial; whereas, the more traditional cross-sectional method and the newer time-sequential methods assume the cohort effects to be trivial, and the cross-sequential method assumes the age-related effects to be so.

Three Issues

Among all the possible issues in the area of psychology that could be beneficially investigated, possibly the three most important topics, in view of the stated goals of this research study, are those of the stability versus the changeability of the human personality; the ability or the lack of ability of older subjects to learn; and the mental rigidity versus mental agility possessed by older persons. It should not be difficult to perceive how these subject areas relate directly to the issue of the older adult as a political actor.

The issues of the changes in personality and the changes in the ability to learn, as well as the presence of mental rigidity in older persons, are all approached as complex subjects. The topic of personality is covered in some depth here in order to stress the various theoretical positions inherent in the disengagement, the activity, the continuity and the life-span development theories. This

comparative theoretical approach is limited to the issue of personality in this research study in order to permit the subject matter relating to change in personality to be developed in a more extended fashion. It should be remembered, however, that the multidimensional and multidirectional concepts applied to both the areas of learning and to the issues of rigidities could, and perhaps should, be developed, time and space permitting, using the same comparative analysis that is presently being used here to develop the section relating to personality.

In the world of research there is seldom only one answer to any one question. This is true for the three issues presently under consideration. The answers depend on the biases of the researchers, the level of analysis involved, the methodology used, and the particular testing or measuring devices used, if any, to obtain the empirical results for the research.

Personality Stability Versus Change in the Older Adult. The disengagement theorists stress that there is a mutual withdrawing of the older individual from society and vice versa. This process is accompanied by a turning inward, an increased interiority, of the older person. Consequently, a researcher who has a theoretical orientation toward the disengagement theory may tend to design research in order to discover signs of the disengagement process. To persons operating from this particular bias, and all researchers operate from some biased position, the human personality does appear to change in old age. The characteristic of personal interiority does appear to increase and a lessened interest in the things of

the wider social world does appear to occur as the older adult continues to age.

The methodology used by many disengagement theorists during the 1960's and first half of the 1970's relied heavily on cross-sectional methodology. This cross-sectional data presents many problems to the aging researcher. Cross-sectional data confounds various types of changes that the individual experiences, i.e., age-graded changes, normative changes, history-graded normative changes, and non-normative changes.

Cross-sectional research frequently involves different cohort groups. For example, for the engagement-disengagement continuum a researcher might utilize ten categories involving 10-year intervals between birth and 100 years of age. That is, persons in the 90-to-100 year category are compared to persons in the 20-to-30 year category. The problems presented with such a research design are many and profound. The confounding of cohorts, of time and of measurement places the older person at a great disadvantage and almost always makes the older person look much worse on certain characteristics than he or she would look otherwise had a sequential research design been used.

The longitudinal research design measures intrapersonal changes in the older adults. Longitudinal designs are usually categorized as either the individual study method or the group study method. With the longitudinal design cohort effects are confounded with time and measurement effects. The researcher frequently cannot be certain as to why a particular change occurred. For instance, did the event

occur because of increasing age of the sample population under study, or did it occur because of the time in history that these people lived (and the culture that they lived in), or are the measurement effects of the research design "coloring" the results?

Back to the original question, the disengagement theorists would probably say, "Yes, human personality changes as the person ages." The problems inherent in this position are related to the following facts: their response is frequently based on a particular theoretical bias, their analysis of the problem at hand is frequently a first-level analysis, their methodology is frequently outdated, and their measuring devices often lack both validity and reliability. Consequently, one is best advised to carefully review several other possible approaches to this issue before formulating an opinion in this area.

The activity theorists stress that life satisfaction is the highest when the aging person replaces primary life activities, which change due to personal or social changes in the person's life, with other comparable activities that meet the needs of the particular person under consideration. The theorist with a bias toward activity theory will often stress continuity of personality, as opposed to the position of the discontinuity of personality, which is the position that is often taken by the disengagement theorist.

The level of analysis used by activity theorists can be first-, second-, or third-level analysis. Also, the emphasis may be on either the personal activity of the individual, the societal mechanisms

that are available to and encourage the older person to remain active or on both the individual and the societal mechanisms.

The methodology used by activity theorists has traditionally relied heavily on both the cross-sectional and the longitudinal methodologies; however, the methodology in the 1970's has also included the use of the sequential-design strategies.

The cross-sectional and longitudinal research designs, as we stated earlier in this section, confound cohort, time and measure qualities in such a manner that it is frequently impossible to determine the characteristics that are caused primarily by the aging process. The sequential research designs do not suffer from this limitation and are now routinely used by activity theorists in conducting research relating to the aging process.

The measurement problems for the activity theorists are essentially no different from those of the disengagement theorists. Validity and reliability are of special concern to most research designs regardless of theoretical orientation.

In summary, the activity theorist would probably respond negatively to the question, "Does personality change significantly as the person ages?" As this response is based on a particular theoretical bias, one is best advised to consider this problem from yet another point of view.

The continuity theorists stress that where life satisfaction is relatively high, there is no appreciable change in the human personality as the person ages. The bias here is toward stressing a continuous quality inherent in the personality; however, there are

times when this continuous quality is interrupted and the personality development becomes discontinuous.

The continuity of personality development, according to Neugarten is based on three primary factors as follows:

1. Personality type.
2. Extent of engagement of disengagement.
3. Extent the person experiences "life satisfaction" or high or low morale (Kimmel, 1980:405-408).

Continuity theorists have, of course, traditionally used the older research designs involving the cross-sectional and longitudinal formats in much the same manner as the other theorists discussed here have used them. There is, however, presently a great deal of current use of the sequential strategies by many of the continuity theorists.

The level of analysis can, of course, involve a first-, a second-, or third-level analysis. The researcher frequently targets for investigation both the individual and the pertinent social structure as well as the interaction between these two entities. The problems of measurement for the continuity theorist remain the same as those for the disengagement and the activity theorist--ones of validity and reliability.

In summary, the continuity theorist would probably respond to the question, "Does personality change significantly as the person ages?" with the staement "It all depends on several important factors and the answer could be either 'yes' or 'no'"; however, they might add, "Some personalities of some older persons do change; although, on the whole personality is a relatively stable cluster of

personal characteristics, and for the majority of persons the personality remains relatively unchanged over the adult years of life."

To obtain yet another perspective on the issue at hand, the position of the life-span development theorists is reviewed. The life-span development theorists, which include life-span development psychologists as well, are devoted to a position that views life as a total life cycle. The older adult can be studied only within the context of the entire life cycle as no one age range is more or less important than any other age range in this cycle. Change and growth are inherent properties of all phases of the human life cycle.

The life-span development theorists are the main opponents of the traditional philosophical position known as the "irreversible decrement model" of aging. In this model, decline is stressed as the main characteristic of old age. This decline is seen as both universal and irreversible in nature. This "gloom and doom" position is perhaps one of the most tenaciously held ideas, by members of the general public, in reference to the aging population today (Hayslip, 1982:no page).

Instead, the life-span development theorists exhibit a bias toward stressing that change in all stages of human development is multidimensional and multidirectional. The later stages of life involve a complex pattern of concomitant growth and decline in any one individual. To emphasize a particular element over a more holistic approach is both simplistic and misleading.

Here, the level of analysis may again be one of first-, second-, or third-level analysis; however, the possibility of utilizing first-

or surface-level analysis is, for all facts and purposes, virtually eliminated when utilizing this model. The model forces the researcher to consider too many factors to be readily conducive to a surface level analysis.

The methodology being used by life-span development theorists includes, among others, the sequential research strategies mentioned earlier. The measurement problems experienced by the life-span development theorists remain the same as those experienced by the disengagement theorists, the activity theorists and the continuity theorists.

In reference to the original question asked in the beginning, the life-span development theorists would probably respond to the question, "Does personality change significantly as the person ages?" with "The answer is a simultaneous 'yes' and 'no,'" reply rather than the "yes" reply of the disengagement theorists, or the "no" reply of the activity theorists, or the "yes or no, it all depends on the situation," which would likely be the reply of the continuity theorists.

The reply of "yes and no," not "yes or no, it all depends . . ." would be justified on the basis that change, at all stages of life, is multidimensional and multidirectiona; that some personality characteristics are in fact increasing while others are decreasing; that when one talks about personality, one is talking about a cluster of characteristics, some of which change with age and some of which do not. The answer to the question of whether personality changes in old age depends on which personality characteristics are being

referenced. Some personality characteristics, according to the life-span theorists, tend to change in later life; and other do not.

Intelligence in the Older Adult. This section explores the various issues related to intelligence and its changes in the aging process. First, a definition of intelligence is presented as a starting point. Then the earlier research approaches used in assessing intelligence in the aging population are briefly reviewed, followed by important findings from contemporary research. Brief mention is made of the topics of education and socioeconomic status and their positive correlation with intelligence over the life span. Last, a short discussion is presented on the intellectual performance of the older adult and the factor of speed in testing situations involving intellectual performance.

1. Functional Definition of Intelligence. For the purpose of this research study and to circumvent the ongoing debate pertaining to the definition of intelligence, it is defined here in a broad and all-inclusive manner. Intelligence is the ability to learn or understand, or the ability to deal successfully with new or trying situations. In reference to the main issue being explored in this research study, politics and the older adult, changes in intelligence as the aging process continues are of no small concern. Of course, in standard folklore, intelligence is thought to decline in older adults. This section of the research reviews the "pros" and "cons" of this argument.

"Intelligence" is one word at the semantic level; however, at the symbolic or meaning level it is seldom unitary in concept. What

"intelligence" means depends on the conceptual framework or the theoretical construct utilized to study this area of human performance. Some approaches conceptualize intelligence as a bifurcated model such as verbal abilities versus nonverbal abilities, while others stress verbal abilities versus psychomotor performance (Botwinick, 1978:213). Another approach stresses "fluid" versus "crystallized" intelligence (Horn & Cattell, 1967:107). Still another approach is the Wechsler Decrements Model of Intelligence (Botwinick, 1978:211) which divides intelligence into operational spheres and then subdivides these spheres into subcategories of intellectual functioning.

2. Earlier Research on Intelligence and Aging. For the most part, the earlier literature on intelligence in the aging population has traditionally relied on cross-sectional studies to support their thesis of decline in intellectual performance of the members of the aging group. The members of the older group were handicapped in these cross-sectional comparisons in several ways: usually members of the older group had, on the average, less education than members of the younger groups; the older adults were less value-adjusted to various items on the tests as many of the answers were known only by persons with more recent schooling; the older adults had, on the average, less experience with tests than members of better educated cohorts; the older adults suffered frequently from poorer motivation in taking the tests; the older adults exhibited more anxiety and inhibitions as they encountered situations that were more likely to reveal their various weaknesses and inabilities; older adults were more easily distracted from the tasks involved in completing the

tests; and last, the older adults frequently suffered from various physiological factors, including limitations in vision and hearing, which lowered their performances on these intelligence tests in comparison to members of the younger cohorts.

Cross-sectional research generally tends to place the older adult in a position that is unflattering, whereas longitudinal research does not. Concerning longitudinal studies involving intelligence stability and decline in older adults, Botwinick (1978:208) states that "the newer literature [points] to less decline with age and, in instances, even no decline." Actually, the more recent literature shows, in certain instances, increases in certain facets of intelligence up to and through the age of 70 with only a very slow and subtle decline thereafter (Bromley, 1966:226).

3. Changes in Intelligence. As regards the first efforts to investigate the human faculty of intelligence in the early 1880's up to the period of the 1960's, the consensus of professionals and lay-people alike has been well expressed by Wechsler (1958:135) when he stated:

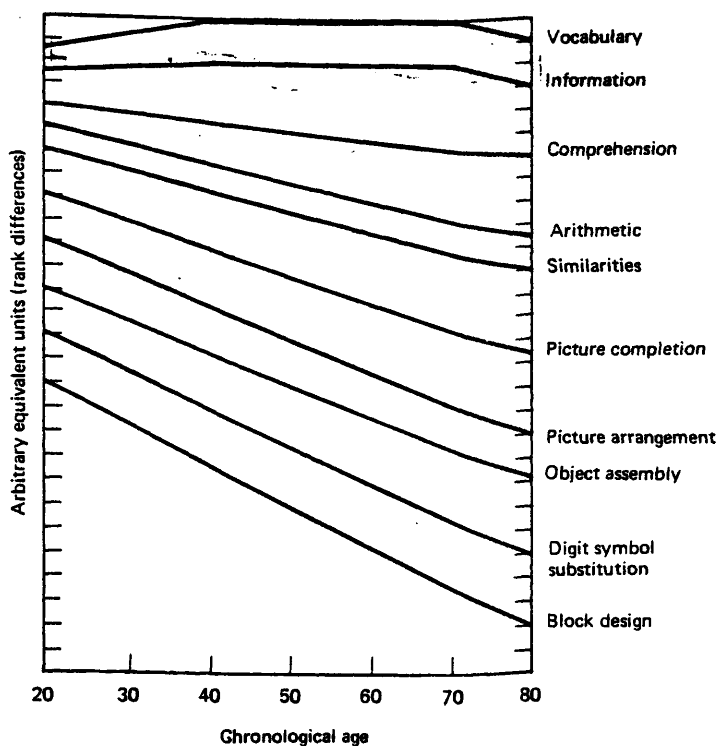
> Beginning with the investigation by Galton in 1883 . . . nearly all studies dealing with the age factor in adult performance have shown that most human abilities . . . decline progressively, after reaching a peak somewhere between ages 18 and 25. The peak varies with the ability in question, but the decline occurs in all mental measures of ability, including those employed in tests of intelligence.

Birren, Botwinick, Weiss, an Morrison (1963:26-70) tested the evolving premise that older adults scored higher on intelligence tests related to verbal ability than they did on intelligence tests related to psychomotor abilities. These researchers found that the

older adults made much higher scores on tests related to general experience, labeled by these researchers "stored information," than they did on test involving, in order, manipulative skills, perceptual functions, and the handling of new information. Here "stored information" relates to both the meaning and the relationship of words. Stored information is one of the primary bases for human social interaction.

Bromley (1966:226), following the lead of Birren and associates, used the Wechsler Adult Intelligence Scale (WAIS) to investigate changes in intellectual performance in older adults. Bromley's (1966:226) research shows that at age 20 and thereafter, there is a rather rapid decline in performance on the WAIS subtests entitled picture completion, picture arrangement, object assembly, digit symbol substitution and block design. His research further shows that there is a milder decline in the subtests entitled comprehension, arithmetic and semantics. On the subtests entitled vocabulary and information, however, the pattern of change is quite different from all the other subtests. In fact, there is an appreciable increase in scores on both these subtests until the age of 40. Furthermore, performance on these tests tends to increase at a more moderate rate after the age of 40 and through the age of 70 (see Figure 7).

The trends in the later literature (the 1970's onward) on intelligence in the aging population are in general agreement with Bromley's research findings although there are different models for presenting the various intellectual performances of older persons.



Expressed in rank units of relative difference.

Source: D. B. Bromley, The Psychology of Human Aging, Baltimore, Md.: Penguin Books, 1966, p. 226.

Figure 7

RELATIVE AGE DIFFERENCES AND DECREMENTS IN INTELLIGENCE ON SUBTESTS OF THE WECHSLER-BELLEVUE INTELLIGENCE TEST

4. The Correlation of Intelligence, Education, and Socioeconomic Status in Older Adults. Intelligence, education and membership in middle- and upper-class socioeconomic groupings have been found to have strong positive correlations in relationship to older adults. In the Birren and Morrison (1961:363) study, the summary statement with regard to intelligence was that "the age of the person was not at all important to this component [however, t]he educational level was very important to this component. . . ."

The reports in the professional literature clearly establish a positive correlation between education and performance on intelligence tests and socioeconomic status of older adults. Perhaps the best known of these studies in the 1957 study by Pressey and Kuhlen (1975: 101), which found that for different occupations, the respondents were, in general, markedly different in intellectual abilities. Thus older persons of higher socioeconomic status generally scored higher than older persons of lower socioeconomic status on tests of intellectual ability. However, this should not be particularly surprising since socioeconomic status of the respondents is based directly on the educational levels obtained by the respondent, the type of occupation held, or formerly held, by the respondent, and the level of income available to the respondent.

In summary, persons with more education and with higher socioeconomic membership do not tend to show the rates of decline in intellectual function that members of the uneducated and lower socioeconomic classes do. In fact, older members of the middle- and upper-classes frequently continue to increase in the verbal

and general intelligence areas as they age, at least up to the age of 70 when there is a gradual decline as the person continues to age (Bromley, 1966:226).

5. Intellectual Performance of the Older Adult and the Factor of Speed in Testing Situations. To assess the intellectual performance of an older person, which is mandatory if one is to establish scientifically the changes in intelligence as an older adult ages, one encounters the rather complex problem of the speed-in-testing situations--that is, the situation created by the use of timed tests.

In this regard, Botwinick (1978:214) states that:

> The controversy was largely resolved with the study by Doppelt and Wallace (1955) and more recently by Klodin (1975) and Storandt (1976). They gave the WAIS [Weschler Adult Intelligence Scale] without time limits, and found the age patterning of scores essentially the same in both conditions, i.e., speed made relatively little difference. From a psychometric viewpoint, therefore, the controversy centering upon speeded tests no longer seemed of great importance.

Actually, Botwinick can only mean that the issue is largely resolved in his own mind, for it is not so viewed by many researchers in the current professional literature. The importance of time in testing varies with the situation under consideration; this is referred to as "a situationally dependent variable." More available time for testing will not necessarily increase the scores of all older people on all tests all the time, but more time in testing will increase the scores of some older people on some of the tests some of the time.

Through a series of rather complicated, but fully documented test designs, Botwinick (1978:185-207) has shown that in situations

involving psychomotor activities, new task comprehension, or situations involving rapid change in "mental set," the older adult is slower in performance than the members of younger cohort groups.

Botwinick (1978:203-204) sums up this situation as follows:

> Much of the evidence points to the central nervous system as the antecedent of the slowing in later life but, for the most part, the evidence is indirect and based upon negative results. First, sensory mechanisms have been judged unlikely as the basis of the slowing, since the old remain slower than the young when the intensity of stimulation is functionally equated between age groups. Also, the old are slower to respond than the young when the stimulus is of sufficient strength as to not be (sic) an issue. Second, peripheral neuromuscular mechanisms have been judged unlikely as the basis of the slowing as determined by the speed of impulse conduction via peripheral nerves. These are so rapid and take so little time as to be unable to account for the slowing with age of voluntary behavior.

Botwinick's point is well taken when he states that sensory mechanisms are unlikely to cause the slowing, since the old are still slower than the young, even when the intensity of stimulation has been functionally equated between age groups. In the functional equating of the intensity of stimulation, the performance level of respondents must to raised to a specified, prestated level. For example, each respondent is tested until he or she reaches 70 percent efficiency on the task at hand, and then all respondents are tested under competition conditions.

It does appear reasonable from the general research data available and from a close examination of the research design that the central nervous system is, in fact, part of the antecedent conditions for the slowing of intellectual responses in adults. It also appears logical that the central nervous system may constitute

only a part of the antecedent conditions that slow the intellectual responses in the older adult. Older adults in testing situations are subject to a range of social pressures that could provide the potential for encouraging a slower, more guarded response than might be true of members of younger cohorts.

The older adult usually performs slower on intellectual tests, especially those involving manipulative skills, perceptual functions and the handling of new information. This is partly related to the changes occurring in the central nervous system of the older adult. It is also possible that other factors as well are related to this slowing of response by the older adult. A type of anxiety may be established in the timed situation that further exacerbates the deficits occurring in the older adult's performance due to his or her aging central nervous system.

In summary, intelligence turns out to be as multidimensional a concept as personality proved to be earlier in this research study. Also, intelligence, when conceptualized, is always multifaceted. In fact, many conceptualized models investigating intelligence in older adults use bifurcated models referencing verbal abilities on the one hand and various psychomotor abilities on the other hand.

It appears from a wide survey of the current literature that intelligence or intellectual functioning in the verbal area does not decrease with age and that, in fact, intellectual performance increases in this area up to and through the age of 70, at least for persons of the middle- and upper-socioeconomic levels, and declines only very gradually thereafter (Bromley, 1966:226).

Since the verbal component of intellectual performance is the very basis of social interaction, it would appear that under the right circumstances older adults should become more competent in the social areas of life. That this may not actually occur may relate more to environment barriers established in the society that reduce the general social effectiveness of any particular individual in that society than to any performance deficit existing per se in the older adult.

The Concept of Rigidity. After exploring personality and intelligence as multidimensional concepts, it should come as no surprise that rigidity is likewise considered to be multidimensional. Therefore, when people ask, "Do older persons become more rigid as they age?" the question is unanswerable for at least the two following reasons. First, the question is unanswerable because the question implies that there is only one type of rigidity while, in actuality, there are many types. Second, the question is unanswerable, as will be seen later in this study, because rigidity is confounded in such a manner with intelligence and speed of response in basic research designs that it cannot, at least at the present time, be isolated from these two elements.

Botwinick (1978:89) brings several new insights to the issue when he states:

> . . . activities in everyday living require continuous modification of prior experience such that some tendencies are inhibited and others maintained. The susceptibility or proneness to certain behavior tendencies and the difficulty in surmounting or inhibiting them define (the

> problem). The contexts . . . are of various sorts and include perceptual organizations, acquired habits, inhibitory processes, and cognitive abilities.

The key in a concept of rigidity is the susceptibility or proneness to certain behavior tendencies and the difficulty in surmounting or inhibiting these behavior tendencies. Everyone is rigid to some extent, at least in some things. Learned responses are frequently difficult to overcome, regardless of one's age.

It appears from an extensive review of the literature that the researchers in the earlier studies of rigidity were a bit rigid themselves in designing single-dimenional studies relating to ridigity. Most of the studies on rigidity prior to 1960 were of this type.

Heglin (1956:310) did one of the best known early studies of rigidity in 1956. His age groups, 14-18, 20-49 and 50-58, do not quite include the over-65 age group, but generally the trends established by Heglin's research can safely be extended to include the over 65 age group as well. Heglin found that on a series of repetitive-like tasks that changed with time, the older group stayed with earlier solutions that had previously worked but which no longer did, longer than members of the younger groups. As Heglin's findings were well publicized, a research foundation was used to support the already well-established myth that older adults were more rigid than younger adults.

In the 1960's Botwinick (1978:90) reviewed the studies on rigidity in aging, summarizing them as follows:

> The evidence for a rigidity learning deficit in later life does not seem impressive. When there was an indication of such a deficit it tended to be marginal and it was often correlated with an overall deficit in learning performance.

Consequently, we are alerted to two common errors frequently found in studies of rigidity. First, one must not confound learning deficits due to limited intelligence to an isolated factor termed rigidity. Second, the research design should not confound deficit learning antecedents in general and relate these to the results of rigidity.

Schaie (1958:3-4) approached rigidity from a multidimensional standpoint when he investigated three areas of behavioral rigidity: motor-cognitive, personality-perceptual, and psychomotor speed. For Schaie, the motor-cognitive rigidity factor indicates an ability to shift from one activity to another, personality-perceptual rigidity indicates an ability to adjust to new surroundings and the psychomotor speed rigidity factor indicates an individual's rate of emission of similiar cognitive responses.

Schaie found older people to be less flexible on all three types of rigidity when compared to younger cohorts. He then used a covariance technique and held I.Q. firm, but older people still remained more rigid in all three areas of rigidity. Eighteen years later, however, Schaie reversed himself on his earlier findings when he reanalyzed the data of his earlier cross-sectional study using a longitudinal methodology (Botwinick, 1978:110).

In summary, rigidity presents a very special series of problems to the researcher. As has been shown earlier in this study, some facets of intelligence such as problem solving and the learning of new

techniques tend to decrease with age, starting as early as the age of 20. At age 65 and older, the learning deficits in these areas are considerable. If one reaches the age of 65, 75 or 85 and is then asked to take a test on performance skills involving these particular deficit areas of learning, his or her performance levels are likely to be much more limited than that of members of the younger cohorts.

Since most performance tests related to rigidity involve the very learning skills that decay the greatest with the aging process and since it was clearly shown earlier that response time to certain types of intellectual performance tests also decreases, probably due in part to central nervous system decay in the older adult, there is no way to unconfound the data relating to rigidity measurements. The part that represents "true rigidity" in any one of several different areas of performance, the part that represents factors of lower intellectual operations, and the part that represents slower response time are elements that cannot be unconfounded. Hence, the question of ridigity, at least for the present time, is unanswerable.

Sociology and the Older Adult

Specific theories of aging, as is true of any theory, arise from a conceptual or philosophical base. From the 1930's through the early 1950's, the "theoretical frameworks utilized [in the field of aging] were usually implicit and often impressionistic in nature" (Bell, 1976:31). The late 1950's and early 1960's saw a move toward a more systematic development of aging theories. Many of the operant theories of today had their beginnings during this particular period;

for example, disengagement theory (Cumming & Henry, 1961), the activity theory proposed by Birren in the 1950's (Bell, 1978:31), developmental or continuity theory (Anderson, 1958), and role theory (Phillips, 1957) to name just a few. And in the 1970's, Dowd (1975) successfully applied the sociologists' classical stratification theory to the aging process. He then did the same thing with Homan's (1961) exchange theory. Both the stratification theory of aging and the exchange theory of aging, of course, have been well received by the professional community.

This section will present the main sociological approaches to aging theory that have occurred in the twentieth century. This will include a discussion of disengagement theory, activity theory, continuity theory, role theory, stratification theory and exchange theory.

The Disengagement Theory

Cumming and Henry (1961), in their book entitled Growing Old: The Process of Disengagement, developed the first formal theory in the field of gerontology. This disengagement theory had the advantage of being both simple and stylized and was therefore relatively easy to comprehend.

Cumming and Henry (1961) based their cross-sectional analysis on a data base of 275 persons, ranging in age from 50 to 90 years of age. All respondents were middle-class persons residing in Kansas City. Various scholars have subsequently analyzed the data from the

"Kansas City Study" using different theoretical models. The study is consequently well cited in the literature.

Cumming and Henry (1961) state that it is obvious that some type of important change has occurred between the stages of life called "middle-aged" and "old-age." Middle-aged persons are usually fully engaged in the tasks of life and elderly persons are frequently no longer engaged in many of the roles that formerly occupied them during their middle-aged years. In fact, Cumming and Henry stress that elderly persons, on the average, become more and more disengaged from their former middle-aged roles as they continue to age.

Several additional steps are required to complete the main outlines of this theory. First, this disengagement is voluntary on the part of the individual. The older person, in responding to both the subtle and the not so subtle reactions of those about him or her, at some point acknowledges the fact that it would be best for all concerned, for the older person to withdraw and let younger, more capable persons take over the various role functions that the older person is performing. Furthermore, Cumming and Henry state that society condones this "timely transfer of role function" as advantageous to both the continuing efficiency of an ongoing social order and to the general welfare of the older individual so involved.

Not only is this a classic example of the decrement model of aging, but Cumming and Henry also consider this disengagement process to be both inevitable and universal. In fact, Cumming and Henry (1961:7) refer to the aging process as:

> . . . an inevitable mutual withdrawal or disengagement, resulting in decreased interaction between the aging person and others in the social system he belongs to. The process may be initiated by the individual or by others in the situation. The aging person may withdraw more markedly from some classes of people while remaining relatively close to others. His withdrawal may be accompanied from the outset by a preoccupation with himself; certain institutions in society may make this withdrawal easy for him. When the aging process is complete, the equilibrium which existed in middle life between the individual and his society has given way to a new equilibrium characterized by a greater distance and an altered type of relationship.

The disengagement theory, with its emphasis on the universality and the inevitability of this process, caused immediate controversy upon its introduction to the professional community of scholars engaged in the ranks of the various social sciences. "Even more controversial, however, was the theory's statement that, as a natural or normal process, the disengaged person is the happy person" (Botwinick, 1978:62).

The disengagement theory has proved to be a most fertile theory, generating a great deal of research over the two decades following its initial presentation to the professional community. Several of these research studies are as well known as the original "Kansas City Study" itself. The Lowenthal and Boler (1965) study trageted the areas of "voluntary disengagement" versus "involuntary disengagement." There were four groups of older persons involved in this study. Basically, the members of the first group were defined as having minimum social interaction while the members of the second were defined as socially deprived groups; that is, socially deprived because of retirement, widowhood and physical disability. Members of the third and fourth groups, respectively, were categorized as

"not withdrawn-not deprived" and "not withdrawn-deprived." Lowenthal and Boler discovered that the members of the "not withdrawn-not deprived" group had the highest morale. Also, they found that the members of the "voluntary disengaged" scored as high as members of the "not withdrawn-not deprived" group. However, the members of the "involuntary disengaged" group had, on the average, very low morale. Lowenthal and Boler (1965:371) summarize their study by stating, "It is the deprivations themselves rather than consequent changes in social interaction that are decisive."

It would appear that disengagement, life satisfaction and high morale are not positively correlated in any universal sense of the term. Actually, life satisfaction and high morale appear to be positively correlated with activity. If this is so, then the voluntary characteristic stressed by Cumming and Henry in the disengagement theory comes under serious attack. Also, concomitantly, the twin characteristics of "universality" and "inevitability" of the disengaement theory are challenged. In the final analysis, what appeared as part of a "normal developmental process" to Cumming and Henry, appears, on closer observation, to be part of a socially imposed situation determined primarily by a series of barriers in the immediate environment of the older adult.

The Activity Theory

The activity theory had a long incubation period. It appeared in its basic form in the 1950's (Bell, 1976:1) and in its first complete and systematic form over a decade later (Hendricks &

Hendricks, 1979:187). The development of the systematic theory was encouraged by the appearance of the disengagement theory (Cumming & Henry, 1961). Apparently, at no time did persons subscribing to the activity theory contend that the disengagement theory was totally in error. The theory seemed to apply particularly well to many "frail elderly" persons although, at the time, this was only a small portion of the total elderly group.

Blau (1973:13) presents the primary assumption underlying activity theory when he states: "The greater the number of optimal role resources with which the individual enters old age, the better he or she will withstand the demoralizing effects of exit from the obligatory roles ordinarily given priority in adulthood."

There are four postulates in activity theory. These postulates are:

> First, the greater the role loss, the less the participation in activity. Second, as activity levels remain high, the greater the availability of role support for role identities claimed by the older person. Third, the stability of role supports insures a stable self-concept. Finally, the more positive one's self-concept, the greater the degree of life satisfaction. (Hendricks/Dimensions:197)

The Maddox and Eisdorfer (1962) study is as well known as that of Lowenthal and Boler (1965) mentioned early in this section. In this study, the respondents ranged in age from 60 to 94 years of age. The "activity areas" investigated were physical movement, social contacts with family and friends, participation in organizations, work patterns and leisure-time pursuits. Morale was related to feelings in connection with self, family and friends plus feelings of both happiness and usefulness.

Of course, the frail elderly generally rated low in a series of three basic elements: physical activity, health, and work routines. With these exceptions, the findings were clear and unambiguous in relationship to the activity theory; 73 percent of the respondents in the Maddox and Eisdorfer study were either high or low in both activity and morale. This is contrary to the thesis stated by the disengagement theorists that low activity, as an index of the disengagement factor, would be positively correlated with high morale, or high morale would be positively correlated with low activity. Also, once the data are age graded, it becomes apparent that, after the age of 60, activity may appreciably decrease without any significant effect on the morale of the older person involved.

Maddox and Eisdorfer (1962) differentiate between activity that is primarily personal and that which is primarily nonpersonal. The assumption here is that changes in the innerpersonal or intrapersonal sphere will almost inevitably change the interpersonal activities. Thus, Maddox and Eisdorfer formulated the concepts of "activities in the interpersonal realm" and "activities in the non-interpersonal realm." They then demonstrated that it is in the interpersonal realm, as opposed to the non-interpersonal realm, that activity declines the most with age.

Maddox and Eisdorfer found that morale was higher for those respondents who reported high non-interpersonal and low interpersonal activity as opposed to those respondents who reported low non-interpersonal and high interpersonal activities. Maddox and Eisdorfer also delineated in their research study three additional

dimensions related to high morale in aging. First, they found that high morale was sometimes related to activity and sometimes to inactivity but that high morale was always associated with good health; and conversely that poor health, regardless of activity levels, was associated with low morale. Second, they found that respondents higher in socioeconomic status were more likely to report both high activity and high life satisfaction, as opposed to members of the lower socioeconomic groups. Third, they found that persons experiencing the least work-role changes were the most likely to report both high activity and high life satisfaction as opposed to those persons who were active but who lacked work-role continuity. This particular characteristic is probably more closely associated with members of the higher socioeconomic groupings.

The Continuity Theories

The continuity theorists tend to stress the biological, psychological and social changes that occur over a lifetime. Depending on the theoretical bias of the reseacher, any one of these three approaches may be stressed over the other two; however, there is a tendency for psychologists who are continuity theorists to be interested in, among other psychological issues, personality types, learning patterns and coping skills.

Neugarten, Havighurst and Tobin (1968:173-177), all of whom are continuity theorists, state:

> There is considerable evidence that, in normal men and women, there is no sharp discontinuity of personality with age, but instead an increasing consistency. Those

> characteristics that have been central to the personality seem to become even more clearly delineated, and those values the individual has been cherishing become even more salient. In the personality that remains integrated--and in the environment that permits--patterns of overt behavior are likely to become increasingly consonant with the individual's underlying personality needs and his desires.

Reichard, Livson and Petersen (1962) developed a classic topology of personality based directly on their own research findings. Their categories are: the mature type, the rocking chair type, the armored type, the angry type and the self-hater type. Reichard and associates discovered that from early adulthood through advanced old age, the person's basic type of personality and coping skills do not change to any great degree.

Neugarten, Havighurst and Tobin (1968:173) developed another typology of personality, but "utilized sophisticated statistical procedures in order to avoid the methodological criticism that was leveled at Reichard's findings" (Hendrick:199). The personality categories included in the model developed by Neugarten and her associates included the integrated type, the armored-defended type, the passive-dependent type and the unintegrated type. Basically, Neugarten and her associates concluded that personality in old age is but an extension of personality in middle-age--the coping skills remain essentially the same across these two primary stages of life.

Role Theory

Role theory is deeply rooted in the structural-functional sociological perspective, which has been dominant in sociology since

the decline of the ecological orientation of the Chicago "School" in the 1930's. The main theme of this theoretical orientation, as it relates to aging theory, is the emphasis it places on individual adjustment or lack of adjustment to role change as the aging process progresses. The underlying concern is with the aging individuals' declining physical and mental capacities which are needed to meet the demands of the various roles that they occupy.

Role theory is concerned with roles and role incubents. It assumes that stability is the goal of society and that social control and order are necessary to maintain this stability. Role theory stresses that persons occupy roles for various reasons; for example, self-advancement, organizational enhancement, and support and maintenance of certain social, religious or national objectives. As they age, persons discontinue certain roles.

Role theorists stress that aging problems, for the most part, are problems of individual adjustment. The problem is not the fault of society but rather the inability of the individual to cope with his or her new life situation. Thus, role theorists frequently end up "blaming the victim" for his or her age-related problems regardless of what these problems might be.

Stratification Theory

Stratification theory, in its concern for social mobility, class position and social position ". . . has occupied the attention of sociologists perhaps more than any other issue" (Dowd, 1975:10). Stratification theorists usually fall into one of two categories:

either that of the consensual theorists or that of the conflict theorists. The structural-functionalist school of sociology is synonymous with the consensual position, whereas the Marxist school of sociology is synonymous with the conflict position. The former stresses social order, rationality and group consensus; society is a "sorting machine," moving inexhorably to sort individuals into the most appropriate slots in view of their personal characteristics and the needs of society. Conflict theory, on the other hand, stresses "that individuals [must] regain control over social institutions" (Dowd, 1975:12).

Stratification is the study of the methods that a society uses both to distribute its resources and to insure that this distribution is maintained and continued into the future. Education is a prime tool in stratification as it helps to preserve "a stratified inequality" among the peoples of a nation (Bowes, 1972:219).

Durkheim (1947:2) states that society and social reality are "sui genesis," or things in themselves. Man does not alone create his reality but is a recipient of a large part of it based on the level of society into which he is born. All societies of the world are stratified or multileveled collectivities of men.

Dowd (1975:16) adds:

> The point here is, of course, that each generation is composed of members from a variety of social-class, racial/ethnic and religious backgrounds. The tendency of middle-class academicians to ignore this internal differentiation and proceed headlong into grand descriptions of entire generations makes for interesting journalism, perhaps, but violates basic principles of sociological analysis.

The tendency to view all older persons from one position--such as where all older people are viewed as members of the middle class or where all older people are viewed as poverty striken, unhealthy and unhappy individuals--is not in agreement with reality. All older persons may be viewed as a social problem; but, in fact, a great many older persons are no more of a social problem than are their sons and daughters or even their grandsons and granddaughters, for that matter. The whole issue seems to be primarily a matter of economics. Persons of a higher socioeconomic level are in a position to negotiate, in their later years, in a number of ways that members of the lower socio-economic levels are not able to do. Therefore, aging is considerably freer of barriers to services and goods that are wanted, needed or desired by members of the upper socioeconomic classes than is true for the members of the lower socioeconomic classes.

Exchange Theory

Exchange theory is based on stratification theory--the study of the methods that a society uses both to distribute its resources and to insure that this distribution is maintained and continued in the future. Exchange theory, as approached by Dowd (1975:19), is based on the following three major assumptions:

1. The organization of a society reflects the interests of the dominant strata (social classes) within a stratification hierarchy.
2. The dominant strata attempt to maintain favorable institutional arrangements (that is, the greater access

of members of the dominant strata to political, economic, and educational systems) through the exercise of power.

3. The legitimacy attached to institutional arrangements by older people is effected through a process of socialization; however, because socialization is always limited in scope and never totally effective, the legitimacy granted to existing arrangements may be withdrawn.

Exchange theorists frequently view older persons as a social class. On the other hand, since most of the professional literature uniformily stresses that social class and age are two distinctly separate categories, it is exceedingly difficult to withhold judgment in this situation until the complete argument of the exchange theorist has been presented. Once completed, however, this argument is seen to have some very strong points in its favor.

According to exchange theorists, power is the activating element in exchange theory. Power can be equated with possessing resources others desire. Stratification and social class are both based on power, and power is based on the control of desired resources. "Inequality," Dowd (1975:34) states, "is the uneven distribution of any resource, including power; whereas stratification means the relatively permanent power arrangement that both underlie and result from structured inequalities."

Consequently, to the exchange theorist, age strata are basically social conflict groups by their very natures and strive to maintain either participation in or restrict access to the mechanisms of authority, thus further enhancing the power of a particular age

stratum at, of course, the expense of yet another age stratum group. Dowd is saying that the older adults constitute a social class and that this class is involved in a very real dialectic with other social classes, made up of other age stratum groups, over both the exercise of power and the control of resources.

Before the exchange process can be properly evaluated, the types of available resources involved in this exchange process should be clearly established. Dowd (1975:381) identifies five major categories:

1. Personal characteristics, such as strength, beauty, charm, integrity, courage, intelligence, knowledge and so forth.
2. Material possessions, such as money or property.
3. Relational characteristics, such as influential friends or relatives, or caring children.
4. Authority, such as that associated with political office, position in a formal organization, or status within a group (such as the status of parent in the family).
5. Generalized reinforcers, such as respect, approval, recognition, support and other rewards.

Money, of course, is the main exchange element in our society. Since older persons are frequently retired and living on lower incomes, this resource may be severely limited. Also, authority, for those presently retired, is usually limited. Beauty and strength are, respectively, subjective and relative; however, these

characteristics might be expected to exist in rather minimum quantities among the elderly. Yet, on the personal level, many older persons do possess considerable resources. Consequently, as a class, Dowd stresses, older persons do, in fact, possess a real potential power position in the political arena.

Dowd (1975:122-123) sums up the political position of the elderly as follows:

> One wonders, however, whether the bargaining position of old people could be significantly improved. The answer is a qualified "yes." The status of old people can be improved, but it will require a modification of existing behaviors that may not be possible. The key to all of this is engagement. In order for old people to improve their negotiating positions vis-a-vis younger partners, they must remain engaged in exchange networks. This is because exchange relations tend toward balance; however, in order for the balanced state to evolve, the exchange relationship must endure. Consequently, even though a strategy of negotiation by default may be a rational response to an unbalanced exchange in the short run, the long-term solution requires old people to remain active and engaged. The withdrawal into private life, which is characteristic not only of old people but of many in the working class as well, runs counter to the best interests of these groups.

Economics and the Older Adult

The economic assets of and the total available income flow to elderly persons varies greatly. Averaging figures tends to conceal certain economic problem areas that are experienced by various population subgroups. It is the purpose of this section to investigate and clearly delineate the economic positions of these various disadvantaged aging subgroups and at the same time to identify general trends that are applicable to a majority of the elderly population.

This section commences with a discussion of the concept of "superannuation" of the elderly worker. It then reviews the past employment and unemployment figures for the elderly population. The issue of whether the elderly wish to continue to work or to return to work is explored next. In current American mythology, it is assumed that most elderly do, in fact, wish either to continue working or to return to work if they have retired. There are now ample research data to establish some firm trend lines in this particular area; these data are reviewed here. Also, a full discussion of income sources for the elderly is presented, including Social Security, earning, asset income, private pensions, and government employee pensions. To terminate this section, a discussion of poverty and the elderly is presented.

The Concept of Superannuation

As the adult ages, he or she is eventually excluded from the labor market. The age at which this may occur varies according to a number of intervening variables. For many, the age at which this occurs is 65; for others it may be earlier or later. In fact, the application of the concept of "superannuation" is a deliberately manipulated process of excluding older adults from the labor force (Friedman & Sjogren, 1981:127). The concept of superannuation is constructed on the basis of the following premises:

1. The dilution of industrial skills--The simplification and segmentation of tasks minimized the importance

of craft skill and experience by which the older worker formerly had been able to maintain a favored position in the craft system.

2. The introduction of new concepts of industrial efficiency--Output in the new system was determined by the effectiveness with which individuals performing a standardized task could maintain the pace of the productive system; declining speed particularly put the older worker at a competitive disadvantage with the younger men.
3. Changing requirements for supervisory positions--Successful movement from production to supervisory roles was based upon ability to lead a work "team" and deal with its problems of social organization rather than upon mechanical skill alone; this deprived the older worker of the automatic gains in status which came to him with increased skill under the craft system; it also put him at a competitive disadvantage with rising younger men who had mastered the new ground rules for the organization of industrial production.
4. Obsolescence of skills--As techniques changed, new skills had to be learned; preference was given to younger workers for instruction in new skills.
5. The growth of fixed age retirement practices--The growth in size and complexity of industrial enterprises and the development of a professional managerial group, interposed in the traditional owner-employee relationship,

has resulted in a substitution of impersonal age-based employee separation procedures for the individual determinations of retirement age characteristic of the small-owner-operated plant.

6. <u>The growth of industrial pension systesm</u>--The corporate life span exceeds that of any single group of owners, and its obligations do not cease with their death. Considerations of continuing industrial efficiency which led to the development of fixed-age retirement practices also led to the creation of industrial pension systems as compensation for separation. In the logic of corporate survival, it could be justified as a device that avoided a serious impact upon the morale of their continuing work force.

Income and the Elderly

Income for the elderly can come from one of several sources. According to Grad and Eoster (1979:74), the percentages of income that the elderly received from various sources in 1976 were: Social Security, 39% of the whole; earnings, 23%; asset income, 18%; private pensions, 7%; government employee pensions, 6%; and other, 7%.

The question of income for the elderly is easier to address than is the question of income adequacy. In relation to income, the task is to locate the latest appropriate data from the well-stocked U. S. Bureau of the Census Data Bank. In relationship to the

adequacy of this income, many value judgments must be made that directly affect the outcome of the analysis.

Income

Total annual monetary income of persons 65 and over is spread over a wide range (see Table 7). This income is made up of Social Security payments, earnings, asset income, private pensions, government pensions and a small amount from other sources. Each of these areas will be discussed below as will the subject of employment for the older adults.

Social Security. According to the editors of the June 1982 issue of the Social Security Bulletin:

> At the end of February 1982, the Old-Age, Survivors, and Disability Insurance (ASDI) program was paying $12.3 billion in monthly cash benefits to 36,123,025 beneficiaries--an increase of $1.5 billion in the total monthly benefits payable and 332,000 in the number of beneficiaries since February 1981. The OASI program accounted for 95 percent of the rise in the amount of monthly benefits and 100 percent of the increase in the number of beneficiaries. Retired workers were 20,332,241, or 56 percent of the total number of OASDI beneficiaries.
>
> During the 12-month period ended February 1982, the monthly amount of OASI and DI benefits rose 15 percent and 6 percent, respectively. The number of OASI beneficiaries increased 2 percent while the number of DI beneficiaries decreased 7 percent.
>
> Average monthly benefit amounts payable in February 1982 to retired and disabled workers were $386.81 and $412.66, respectively. A year earlier, average benefits were $342.89 for retired workers and $371.10 for disabled workers.

OASDI, hereafter referred to by its colloquial name "Social Security," is a public program that provides several types of pensions, among which is a retirement pension. The retirement

TABLE 7

TOTAL MONEY INCOME OF PERSONS 65 AND OVER, BY SEX: 1977

	Men	Women
Less than $2,000	6%	29%
$2,000 - 3,999	27	40
$4,000 - 5,999	22	14
$6,000 - 7,999	15	7
$8,000 - 9,999	9	4
$10,000 - 14,999	10	4
$15,000 - 19,999	5	1
$20,000 - 24,999	2	-
$25,000 and over	4	1
Total $	100%	100%
Median income	$5,525	$3,088

SOURCE: <u>Consumer Income</u>, U. S. Bureau of the Census. Consumer Price Report, No. 116. Washington, D.C.: U. S. Government Printing Office, 1978, p. 176.

pension is funded in part by the employee and in part by his or her employer during the employee's working years.

The basic rules for drawing retirement under Social Security are that the employee must have worked a certain minimum number of quarters, quarters usually equivalent to ten years of continuous time except for some employees who joined the program in its early years, and the employee must be at least 62 years of age. Married persons receive approximately 150 percent of standard pension entitlements in most cases.

Atchley (1980:13) states:

> Nine out of ten older Americans draw retirement benefits from Social Security. For 80 percent of retired Americans, Social Security is the sole source of income. In 1978, the average annual Social Security pension was $4,700 for married couples, $3,122 for single retired workers and $2,852 for survivors. These pension levels are clearly below the level necessary to provide an adequate income by most standards.

While the average monthly Social Security retirement benefits have increased dramatically since their inauguation in 1940 (Table 8), the Social Security benefits are still unevenly spread among different segments of society. In 1975, 15 percent of the elderly recipients received the minimum possible annual payment of $1,125.60 which was $93.80 per month.

Women in general, excluding the career woman, make up approximately half of those drawing minimum Social Security benefits. Of course, the factors that result in these minimum Social Security payments are the same factors that cause this group to have few or no assets with which to supplement this poverty-level income. Also, many widows who have never worked, draw more Social Security than

TABLE 8

AVERAGE MONTHLY SOCIAL SECURITY RETIREMENT BENEFITS, BY TYPE OF RECIPIENT:

UNITED STATES, 1940-1978

	Retired Workers		Retired Couples		Survivors	
Year	Actual Amount	Constant 1967 Dollars	Actual Amount	Constant 1967 Dollars	Actual Amount	Constant 1967 Dollars
1940	$22.60	$53.81	$34.73	$82.69	$20.23	$48.29
1945	24.19	44.88	37.01	68.66	20.19	37.45
1950	43.86	60.83	67.46	93.56	36.54	50.68
1955	61.90	77.18	94.97	118.42	48.69	60.71
1960	74.04	83.47	112.76	127.13	57.68	65.03
1965	83.92	88.80	127.55	134.97	73.75	78.04
1970	118.10	101.55	179.29	154.16	101.71	87.45
1975	207.18	128.52	312.27	193.72	192.33	119.31
1978	260.21	139.82	391.67	310.46	237.63	127.68

Source: Editors, "Average Monthly Social Security Retirement Benefits." Social Security Bulletin 35 (June 1982):159.

many single working women. For example, only 11 percent of the widows drew the minimum pension in 1975, while 28 percent of the retired women workers drew this minimum allotment. In addition, a quarter of the black men and almost a quarter of the black women drew the minimum allotments allowed under Social Security during 1975 (Atchley, 1980:139).

Earnings and the Elderly

The employment patterns of persons over 65 years of age varies over a wide range. Atchley (1980:138) states that in 1975, 16.4 percent of "family heads" were employed full time; 11.7 percent, part-time; and 71.9 were not employed. The respective median incomes for these groups were $18,234, $9,840, and $7,086. Atchley also states that in 1975, 7.0 percent of unrelated individuals age 65 or over--that is nonmarried members--were employed full-time; 8.8 percent, part-time; and 84.2 percent were not employed. The median incomes for these "singles" categories were $7,793, $5,030, and $3,164, respectively.

From these data it is easy to see that "family heads" who are 65 years of age or older are more than twice as likely to be employed full-time (16.4 versus 7.0 percent) and to have a median income more than double that of "unrelated individuals" who are in the elderly group.

Assets Income. Approximately one-fourth of all married couples and nearly half the unrelated individuals had absolutely no financial assets in the year 1967, while 67 percent of the elderly

couples and 80 percent of the unrelated couples had less than $5,000 in financial assets during the same period. Based on the highest asset range of $5,000 there would be no more than $400 of income flow per year, which is slightly more than one dollar per day available to these persons (Kart, 1981:178). Income from assets for the great majority of the elderly is consequently negligible. On the other hand, average income from assets, when one includes the income from assets owned by the wealthiest 2 or 3 percent of the elderly people living in the United States, is, in itself, a rather impressive figure at 18 percent of total income available to the elderly (Grad & Eoster, 1979:74; Kart, 1981:178).

Nonliquid assets are usually defined so as to include all items that are not easily converted to a cash flow. Homes are the most common nonliquid asset owned by the elderly. About three fourths of all elderly persons own their homes, and four fifths of this group own their homes free of any mortgages (Kart, 1981:178).

This could be interpreted to mean that the required income flow for the elderly could be significantly decreased because a majority of the elderly own mortgage-free dwellings. Nevertheless, this may not be true.

Friedman and Sjogren (1981:16) state:

> Previous work on the economic well-being of the elderly and specifically on asset ownership, has found that the financial position of many older and retired persons is precarious at best. For example, . . . while asset ownership is common among those approaching retirement age, the value of owned assets is very low, particularly when equity in a home or residence is excluded. The findings do not support the common belief that assets accumulated by older persons during their younger and

> more active years are a means of offsetting the drop in income that typically accompanies retirement. On the contrary, it appears that for most older persons, asset liquidation cannot be a significant source of funds for household consumption.

They (Friedman & Sjogren, 1981:30) go on to state:

> One way of illustrating how little assets most older Americans have is to translate the value of these assets into annuity income. As noted, married men had more assets than other groups: their median amount of assets was approximately $20,000. If a man aged 66 (whose wife's age is 64) converted all his assets into a lifetime income-producing annuity contract, then the annual income from this annuity would be only $1,900 (assuming that the amount is reduced by one-third after one's spouse dies). If the husband's age is 70 and the wife's age is 68, the annual income would be approximately $2,100. If only assets other than equity in a home are converted into an annuity contract, the annual income would be only about one-third of these amounts.

Kart (1981:178) states:

> Atchley (1980) contends that homeownership really does not reduce income requirements for aged persons. He [Atchley] suggests that homeownership is worth less than $500 per year in terms of reducing income needs. Just how much equity do the elderly have in their homes? Reviewing findings from a 1968 survey of the aged, Murray (1972) reports that 63 percent of aged homeowning families and 56 percent of unrelated individuals who own homes have $10,000 or more equity in their homes. Until very recently, though, this equity was not available to the aged homeowner for day-to-day living expenses. Since January 1, 1979, the Federal Home Loan Bank Board has allowed federally chartered savings and loan associations to offer reverse annuity mortgages. Under this mortgage, a homeowner may sell some equity in the house, receiving in return a fixed monthly sum based on a percentage of the current market value of the house.

In summary, in reference to liquid and nonliquid assets, the large majority of the elderly possess only small amounts of each. In any case, they do not possess enough of either to affect significantly the total income that they need to survive from day to day.

'Private Pensions. Almost 44 percent of all wage and salary workers in private industry were covered by some sort of private pension in 1972. Of the white men, 52 percent were covered by private pensions and this was the first year that a majority of this group was covered. Approximately one third of both the white women and of the non-white group were covered during this period (see Table 9).

Some private industries offer much higher pension coverage for their employees than others. For example, the communications and the utilities provided 82 percent of its employees with pension coverage in 1972, while the construction and service industries provided coverage for only 34 and 29 percent of their employees, respectively (see Table 9).

Government Employee Pensions. Persons in the public sector--those working for federal, state or local governments, or public school and public universities--are usually covered by public pensions. In fact, 80 percent of these employees were covered in 1980 (Atchley, 1980:142). These pensions are usually quite high compared to the private pension system. Atchley (1980:142) states:

> Public pensions also fare better as an addition to Social Security. For example, in 1967 private pensions provided only $972 on the average in supplements to retired couples' Social Security, while public pensions averaged $1800 as supplements to Social Security.

To gain some perspective on the relative cost of government employee pensions and certain other social service programs, one can compare the retirement payments from civil service

TABLE 9

PENSION COVERAGE FOR WAGES AND SALARY WORKERS IN PRIVATE INDUSTRY:

APRIL 1972

Workers	Percent
All full-time and part-time employees	43.7
Full-time employees only	47.0
Men	52.0
Women	36.0
Whites	48.0
Nonwhites	39.0
Full-time employees, by industry	
Communications and public utilities	82.0
Mining	72.0
Manufacturing	
Durable goods	63.0
Nondurable goods	57.0
Finance, insurance, and real estate	52.0
Transportation	45.0
Trade	
Wholesale	48.0
Retail	31.0
Construction	34.0
Services	29.0
Full-time employees, by earnings	
Men earning less than $5,000	26.0
Women earning less than $5,000	31.0
Men earning $5,000-9,999	58.0
Women earning $5,000-9,999	58.0

Source: C. S. Kart. The Realities of Aging: An Introduction to Gerontology. Boston: Allyn and Bacon, Inc., 1981, p. 195.

retirement, military retirement and railroad retirement to the payments under Social Security, Medicare and Medicaid (see Table 10). It should be noted that persons employed in the public sector traditionally receive higher retirement payments than do those in the private sector.

Employment and the Older Adult. Data reflecting the employment rates for males 65 years of age and older show a long-term downward trend. Reviewing the latest available data in this area from the Bureau of Census, it can be seen that employment for this group was 2,191,000 in 1960; 2,084,000 in 1970; and 1,842,000 in 1978. In the 1980 census, it is anticipated that another decrease will occur in reference to the 1978 figures (see Appendix B).

For females 65 years of age and older, the employment trend line is contrary to the downward trend for older males. In 1960, for example, 882,000 elderly females were employed in the labor force; in 1970, there were 1,023,000 elderly females; and in 1978, 1,077,000 (see Appendix B).

The percentages for each age category employed in the labor force are presented in the Bureau of the Census publication entitled Statistical Abstract of the United States, 1976 (Statistical Abstract of the U. S., 1976:355). In the older adult employee groups, the figures for both males and females have declined steadily and are predicted to continue to do so through 1990 (see Table 11). Siegel (1976:51) provides a breakdown of worker proportions for the population 65 years of age and older by age, race, and sex, with projections through the year 1990 (see Table 12).

TABLE 10

FEDERAL SPENDING FOR THE EDLERLY: FISCAL 1969, 1979

	Fiscal 1969 (Billions of Dollars)		Fiscal 1979 (Billions of Dollars)	
Social Security	$24.7	62.2%	$90.1	59.0%
Medicare	6.6	16.6	30.1	19.7
Medicaid	0.9	2.3	4.2	2.8
Civil service retirement	2.4	6.0	12.2	8.0
Military retirement	2.4	6.0	10.0	6.6
Railroad retirement	1.5	3.8	4.2	2.8
SSI	1.2	3.0	1.8	1.2
Totals	$39.7	99.9%	$152.7	100.1%
All federal outlays	$184.5		$500.2	
Spending on elderly as percent of total outlays	21.5%		30.5%	

Source: R. J. Samuelson. "Busting the U. S. Budget--the Costs of an Aging America." National Journal 113 (February 1978): 258.

TABLE 11

LABOR FORCE PARTICIPATION RATES (PERCENT) BY AGE AND SEX:

1960-1975, AND PROJECTIONS TO 1990

	1960	1965	1970	1975	1980	1990
Male						
16-19	58.6	55.7	57.5	60.2	62.0	62.2
20-24	88.9	86.2	85.1	84.5	84.5	82.7
25-34	96.4	96.0	95.0	94.1	84.3	93.7
35-44	96.4	96.2	95.7	94.9	94.7	94.0
45-54	94.3	94.3	92.9	91.9	90.5	89.8
55-64	85.2	83.2	81.5	74.7	73.8	69.2
65+	32.2	26.9	25.8	20.8	19.4	16.2
Female						
16-19	39.1	37.7	43.7	49.0	51.3	54.9
20-24	46.1	49.7	57.5	64.0	67.5	74.7
25-34	35.8	38.5	44.8	54.4	58.4	66.0
35-44	43.1	45.9	50.9	55.7	58.1	63.4
57-54	49.3		54.0	54.3	56.8	59.9
55-64	36.7	40.6	42.5	40.7	41.6	42.2
65+	10.5	9.5	9.5	7.8	7.7	7.2

Source: Statistical Abstract of the United States, 1976. Bureau of the Census. Washington, D.C.: U. S. Government Printing Office, 1976, p. 355.

TABLE 12

WORKER PROPORTIONS FOR THE POPULATION 65 YEARS OLD AND OVER BY AGE, RACE, AND SEX: 1950 TO 1990

Age, Race, and Sex	1950	1955	1960	1965	1970	1975	1980	1990
All Classes								
Male								
65 years and over	45.8	39.6	33.1	27.9	26.8	21.7	20.1	16.0
65 to 69 years	(NA)	57.0	46.8	43.0	41.6	31.7	29.9	26.0
70 years & over	(NA)	28.1	24.4	19.1	17.7	15.1	12.9	10.0
Female								
65 years and over	9.7	10.6	10.8	10.0	9.7	8.3	8.0	7.5
65 to 90 years	(NA)	17.8	17.6	17.4	17.3	14.5	14.4	13.9
70 years & over	(NA)	6.4	6.8	6.1	5.7	4.9	4.4	4.3
Blacks and Other Races								
Male								
65 years and over	45.4	40.0	31.2	27.9	27.4	20.9	(NA)	(NA)
65 to 69 years	(NA)	(NA)	(NA)	(NA)	(NA)	(NA)	(NA)	(NA)
70 years & over	(NA)	(NA)	(NA)	(NA)	(NA)	(NA)	(NA)	(NA)
Female								
65 years and over	16.5	12.1	12.8	12.9	12.2	10.5	(NA)	(NA)
65 to 69 years	(NA)	(NA)	(NA)	(NA)	(NA)	(NA)	(NA)	(NA)
70 years & over	(NA)	(NA)	(NA)	(NA)	(NA)	(NA)	(NA)	(NA)

Source: Jacob S. Siegel, "Demographic Aspects of Aging and the Older Population in the United States." Bureau of the Census, Series P-23, No. 59. Washington, D.C.: U. S. Printing Office, 1976.

According to the total labor force figures developed by the U. S. Department of Labor and projected through the year 1995, older adults, both male and female, will constitute less and less of the total labor force in the future (see Tables 13 and 14).

Reviewing the unemployment figures for the members of the group 65 years of age and older, it can be seen that 96,000 elderly men listed themselves as unemployed in 1960; 71,000 did so in 1970; and 81,000 did so in 1978. Among elderly females, 25,000 listed themselves as unemployed in 1960; 33,000 did so in 1970; and 43,000 did so in 1978 (see Appendix B).

Future projections of labor force participation by older adults and the elderly are almost unanimous in projecting a decreasing rate for both groups through the year 2000. Hess (1980:194) states that "between 1960 and 1976, workers increasingly left the labor force at earlier ages." For example, he states that in 1960, 91.6 percent of the 55 to 59 year olds were either working or looking for work. In 1976, the latest figures available for this category show that only 83.6 percent of the 55 to 59 year olds were either working or looking for work and that only 63.7 percent of the 60 to 64 year olds were doing the same (Hess, 1980:194).

Since many elderly persons are not employed, the question arises as to whether they would like to be employed. The issue is more complex than it would seem at first. Hess (Hess/Aging:194) states that "income adequacy is the crucial determinant of whether

TABLE 13

TOTAL LABOR FORCE, BY SEX AND AGE, SELECTED YEARS: 1965-1995

Sex and age	Number (thousands)							Average annual rate of change (percent)		
	1965	1970	1975	1979	1985	1990	1995	1965-75	1975-85	1985-95
Total, both sexes	77,178	85,903	94,793	104,996	115,043	121,456	124,583	2.06	1.94	0.80
MALE										
Total, 16 years old and over	50,946	54,343	57,706	61,466	64,951	67,059	68,398	1.24	1.18	.52
16 to 24 years old	9,757	11,773	13,313	14,292	13,514	12,205	11,294	3.11	.15	-1.79
25 to 34 years old	10,653	11,974	14,456	16,402	18,506	18,982	17,561	3.05	2.47	-.52
35 to 44 years old	11,504	10,818	10,583	11,615	14,494	16,869	18,449	-.83	3.14	2.41
45 to 54 years old	10,131	10,487	10,464	10,088	9,718	10,888	13,233	.32	-.74	3.09
55 years old and over	8,899	9,291	8,890	9,069	8,719	8,115	7,861	-.01	-.19	-1.04
FEMALE										
Total, 16 years old and over	26,232	31,560	37,087	43,531	50,092	54,397	56,185	3.46	3.00	1.15
16 to 24 years old	5,894	8,143	10,175	11,604	12,040	11,331	10,474	5.46	3.91	-1.39
25 to 34 years old	4,336	5,704	8,473	11,208	14,640	16,096	15,090	6.70	5.47	.30
35 to 44 years old	5,724	5,971	6,496	8,134	11,086	13,827	15,674	1.26	5.34	3.46
45 to 54 years old	5,714	6,533	6,667	6,861	6,746	7,830	9,672	1.54	.12	3.60
55 years old and over	4,563	5,209	5,277	5,724	5,580	5,313	5,275	1.45	.56	-.56

Source: Social Indicators III: Selected Data on Social Conditions and Trends in the United States. Bureau of the Census. Washington, D.C.: U. S. Government Printing Office, 1980, p. 351.

TABLE 14

TOTAL POPULATION, LABOR FORCE AND NONWORKERS, BY SEX AND AGE, SELECTED YEARS: 1950-1995

Age, sex, and labor force participation	Average annual rate of change (percent)								
	Actual						Projected		
	1950-55	1955-60	1960-65	1965-70	1970-75	1975-79	1979-85	1985-90	1990-95
Total population	1.72	1.70	1.45	1.05	0.83	0.81	0.90	0.89	0.74
Under 16 years old	3.45	2.76	1.29	-.27	-1.36	-1.58	.30	1.11	1.06
16 to 64 years old	.69	.98	1.45	1.66	1.63	1.52	.99	.65	.57
65 years old and over	3.17	2.76	2.02	1.70	2.20	2.38	1.70	1.76	1.03
WORKERS									
Total, 16 years old and over	1.28	1.16	1.35	2.14	1.97	2.56	1.52	1.08	.51
Male	.88	.57	.83	1.29	1.20	1.58	.92	.64	.40
Female	2.23	2.45	2.39	3.70	3.23	4.00	2.34	1.65	.65
16 to 64 years old	1.26	1.25	1.43	2.20	2.10	2.60	1.61	1.12	.54
65 years old and over	1.68	-.69	-.55	.71	-1.83	1.11	-1.50	-.25	-.90
NONWORKERS									
Total, all ages	2.03	2.07	1.52	.31	-.04	-.68	.32	.70	.98
16 to 64 years old	-.30	.46	1.49	.59	.62	-1.07	-.70	-.80	.66
65 years old and over	3.63	3.67	2.59	1.89	2.88	2.56	2.11	1.98	1.22

Source: Social Indicators III: Selected Data on Social Conditions and Trends in the United States. Bureau of the Census. Washington, D.C.: U. S. Government Printing Office, 1980, p. 351.

an older person retires or continues to work." Refining this concept still further and after analyzing all the related issues, it would appear that income adequacy may instead be utilized as a surrogate factor that relates generally to the desire to retire when the opportunity presents itself.

There are a multitude of factors involved in any one decision to continue or to discontinue employment. Hess, for example, divides these issues into two main categories: "push" and "pull factors." Some of the push factors--those elements that encourage a person to leave his employment--are: diminished opportunities for self-employment, increased need for newly trained technicians, and an expanding pool of younger workers at the entry levels. Some of the pull factors--those elements that encourage a person to seek retirement--are: secured pensions, health factors, and a wish to enjoy leisure after a lifetime of work. These push and pull factors have produced a new phenomenon in history: a group of older adults who are no longer engaged in any type of productive labor (Hess/Aging:191).

It appears that when "adequate" (in the elderly person's mind) retirement income is assured, the person with the least satisfying jobs indicate the greatest readiness to retire early. The least satisfying jobs are those that pay low salaries, have low educational requirements for job entry, and are rated low in job status. On the other hand, in those jobs with high pay, high educational requirements for job entry, and which are rated high in job status, the job occupants are less willing, on the average, to

retire early, at least in comparison to those persons with less satisfying jobs (Hess:194).

Contrary to what the "man in the street" may think, the majority of elderly people do not desire to go back to work, regardless of their personal situations (see Table 15). Thus the Protestant work ethnic seems to be inappropriately applied at times to the members of the elderly group. There are, of course, exceptions to the rule, especially when the older person is subsisting in a situation of dire poverty.

A need for income to survive can "push" an elderly person into seeking and accepting, where the possibility exists, employment by those ". . . minority of old persons who desire to remain in the labor force, most of whom desperately need the additional income, but the great majority [of older people] prefer not to work" (Hess:189).

Income Adequacy

There are a number of ways to "estimate" income adequacy for the elderly. Here the income replacement factor method is first reviewed and this is followed by various research findings and evaluations in this area.

The replacement factor is one important measure of the relative adequacy of payments under the OASDI program. The replacement factor is the comparison ratio between the average of the first full year of Social Security income and the average of the last full year of earnings for workers in general. It is here, in the area of replacement ratios, that the payoffs can be seen for different

TABLE 15

TO WORK OR NOT TO WORK

	Income				
	Total %	Under $3,000 %	$3,000-6,999 %	$7,000-14,999 %	$15,000 up %
Would like to work	31	43	31	20	23
Would not like to work	65	54	64	76	74
Not Sure	4	3	5	4	3

Source: L. Harris and Associates, _The Myth and Reality of Aging in America_. Washington, D.C.: National Council on the Aging, 1975, p. 89.

classes of wage earners. From Table 16 it can be seen that the low earners presently have a higher replacement ratio than do either the earners in the average or maximum income categories. This is forecasted to remain true through at least the year 2000; however, the downward trend in all future replacement ratios for all future retirees should be carefully noted (see Table 17).

Various countries, of course, use various replacement ratios. In a list of 12 randomly selected Western industrialized countries, the replacement rate of 38 percent for retired single persons in the United States ranked eighth between a high of 67 percent in Italy and a low of 26 percent in the United Kingdom. For retired couples the replacement rate in the United States of 57 percent ranked fifth between a high of 76 percent in Sweden and a low of 39 percent in the United Kingdom. The United Kingdom, consequently, maintained the lowest replacement rating for both retired single persons and couples (see Table 18).

Even among retired couples, however, there is a earnings income differential at work. The low earners, of course, have the highest replacement rates, and the highest earners have the lowest (see Table 16).

Brotman (1978:1626) compares "operating expenses" for family units only, dividing his data into "Family Head Under 65" and "Family Head 65 Years and Over (see Table 19). In this particular research study, Brotman found that the elderly spent more on three items in his inventory than did the younger respondents: housing, food and health care. The members of the younger group spent more on four

TABLE 16

ACTUAL EARNINGS REPLACEMENT RATES PROVIDED BY SOCIAL SECURITY FOR COUPLES RETIRING IN 1968-1975

Preretirement Earnings	Actual Replacement Rates
Total	42
$1,000-3,999	63
$4,000-5,999	52
$6,000-7,999	48
$8,000-9,999	45
$10,000-12,499	37
$12,500-14,999	32
$15,000 and over	25

Source: Executive Summary of the Technical Committee on Retirement Income. The 1981 White House Conference on Aging. Washington, D.C.: U. S. Government Printing Office, 1981, p. 7.

TABLE 17

PROJECTED REPLACEMENT RATIOS OF WORKERS RETIRING

Year	Low earners (%)	Average earners (%)	Maximum earners (%)
1980	59.4	46.6	29.3
1985	53.4	41.6	23.3
1990	53.7	41.8	24.1
1995	53.6	41.8	24.8
2000	53.6	41.8	25.7

Source: A. Haeworth Robertson, "Financial Status of Social Security Program after the SocialSecurity Amendments of 1977." _Social Security Bulletin_ 41 (1978):21-30.

TABLE 18

REPLACEMENT RATIOS FOR SOCIAL SECURITY PAYMENTS FOR SELECTED COUNTRIES, 1975

Country	Single Retired Worker (%)	Retired Couple (%)
Austria	54	54
Canada	39	57
Denmark	29	43
France	46	65
Federal Republic of Germany	50	50
Italy	67	67
The Netherlands	38	54
Norway	41	55
Sweden	59	76
Switzerland	36	53
United Kingdom	26	39
United States	38	57

Source: L. Haanes-Olsen, "Earnings-Replacement Rate of Old-Age Benefits, 1965-75, Selected Countries," Social Security Bulletin 41 (1978):3-14.

TABLE 19

OPERATING EXPENSES: A COMPARISON BY AGE GROUP

	Family Head Under 65	Family Head 65 and Over
Housing	26.0%	28.9%
Food	18.2	21.4
Health care	4.8	8.3
Clothing	7.3	5.4
Furniture & household equipment	4.4	3.2
Recreation	7.1	6.2
Alcohol & tobacco	2.3	1.7
Transportation	17.9	12.8
Other (gifts, contributions, personal care, insurance, etc.)	12.0	12.1

Source: H. B. Brotman. "The Aging of America: A Demographic Profile." National Journal 13 (7 October 1978):1626.

items in Brotman's inventory than did the older respondents: clothing, furniture, recreation and transportation. Since there is more to spend, the members of the younger group have a larger choice of discretionary spending, which is readily apparent in their expenditure pattern.

Atchley (1980:3) makes a strong indictment against many estimates of income adequacy for the elderly when he states:

> All estimates of this variety [of income adequacy for the elderly] tend to fall short of the actual requirements because they do not include any slack for "contingencies." For example, slightly more than one out of every ten older people will end up in a hospital this year and the average stay will be <u>12 days</u>. The cost will run about $1,200 for the hospital alone. It is not difficult to see what such an expenditure would do to an annual budget of $3,000. Even if the individual has hospitalization insurance (and only about half of the older population does), and Medicare pays part of the cost, the individual will still have to cover about a third of the cost of the health care.

This review of income adequace would not be complete without some mention of the problems that some women have in this area. Women have not generally been well treated by the Social Security system although some of these problems have been or presently are being rectified. Many of the assumptions about the roles and needs of women that were prevalent in 1935 when the Social Security Act was conceived are no longer considered to be valid assumptions today. Social change has made many of these program guidelines seem to be nothing more than gross inequalities. The publication entitled <u>Women and Social Security: Adapting to a New Era</u> (1975), published by the U. S. Senate Special Committee on Aging states:

1. In some instances women cannot generate as many benefits for their family members as men can. For example, a

man cannot receive a benefit from his wife's earnings unless he can prove that he has been receiving at least half his support from her. There is no such requirement for women. The Supreme Court has recently ruled that this provision of the Social Security Act is unconstitutional.

2. A divorced woman can receive benefits from her former husband's earnings if they have been married for at least 20 years (later changed to 10 years). A divorced husband cannot receive benefits from his former wife's earnings.
3. A couple who both worked may receive less in retirement benefits than a couple where only the husband worked, even though both couples had the same earnings and contributions.
4. Homemakers are not covered by Social Security, and an early divorce or the death of a spouse can result in the homemaker's receiving no Social Security benefits (Women and Social Security:24).

Poverty

The poverty level is an artificial economic "cutoff point" established by some person or persons in positions of recognized authority. It is usually a stated monetary figure representing total family income. Families receiving less than the stated figure are considered to be disadvantaged in their quest to obtain the

necessities with which to sustain life. For example, for elderly persons in 1977, the poverty level was set at $3,637 for a two-person family and $2,895 for a single person. That is between $200 and $300 per month for these elderly persons. At this level, one out of seven elderly persons, in the richest country in the world, still fell below the poverty level.

Hess and Markson (1980:206-207) state:

> If the near poor [those not more than 25% above the poverty cut-off point] are added to the official poverty figures and the hidden estimates (those in institutions or the homes of relatives), more than 7 million older Americans would have incomes below the poverty line or so very close to it that they would have difficulty appreciating the difference.

Based on data from 1975, Atchley (1980:137) gives us the percentages of older persons by household type, race and ethnicity level, that are below the poverty level (see Table 20). It will be noted that both black and Hispanic family units are almost four times as likely to have a poverty status as are white family units. Among the elderly individual units, with both sexes averaged together, the black individual units are more than twice as likely to be in poverty than are the white individual units, and the Hispanic individual units are almost twice as likely to have a poverty status than are the white individual units.

Presenting a percentage distribution by income level and utilizing the Bureau of Labor Statistics (BLS) guidelines, Atchley (1980:206) presents data for several ranges of budget levels. These data permit the family-unit budget to be compared for the head of family that is below the age of 65 and for the head of family over the age of 65. The data on individuals 65 years of age and over

TABLE 20

PERCENT OF OLDER PERSONS IN HOUSEHOLDS WITH INCOMES BELOW THE CENSUS POVERTY LEVEL BY HOUSEHOLD TYPE, RACE AND ETHNICITY: UNITED STATES, 1975

	Household Type			
		Individual, Age 65 or Over		
	Family with Head Age 65 or Over	Both Sexes	Male	Female
Total	8.0	31.0	27.8	31.9
Race				
White	6.7	28.0	23.8	29.1
Black	23.6	61.1	51.8	65.8
Other races	21.6	59.9	-	-
Ethnicity				
Spanish Origin	25.9	52.5	35.3	60.3

Source: R. C. Atchley. _The Social Forces in Later Life: An Introduction to Social Gerontology_. Belmont, Calif.: Wadsworth Publishing Co., 1980, p. 137.

can then be compared to either category in the family unit category (see Table 21).

Poverty, as was stated earlier, is not spread equally among the races and sexes. According to the Report on the Mini-Conference on Concerns of the Low Income Elderly (1981), older blacks (36%) and Hispanic Americans (22%) are more likely to be poor or below the poverty level than elderly whites (12%). In addition, elderly women (16.7%) are more likely to be poor than elderly men (10%). In 1975, the median income for a man over 65 was $4,959, but for an elderly woman it was $2,642. Of the elderly living in rural areas, 10% are poor while 11% of those living in metropolitan areas are poor.

The most complete and up-to-date information pertaining to elderly persons below the poverty level is contained in the Bureau of the Census publication entitled Current Population Reports, Series P-60, No. 120 (1979:491-494). These data provide both the number and the percentage of the elderly below the poverty level, as well as the poverty rate for the population as a whole. This data set is broken down along gender, race and ethnic lines (see Appendix B).

In summary, the older worker is usually forced out of the labor market. In retirement, several income streams can make up his or her total income; however, for most of the elderly, total income is based on Social Security payments. For many, this source of income still leaves them in a state of poverty.

TABLE 21

PERCENT DISTRIBUTION INCOME BY INCOME LEVEL, HOUSEHOLD TYPE, AND AGE OF HOUSEHOLD

UNITED STATES: 1975

	Families, Head Age 14–64			Families, Head Age 65 or Over			Individuals, Age 65 or Over		
	Dollar Definition	Percent	Cumulative Percent	Dollar Definition	Percent	Cumulative Percent	Dollar Definition	Percent	Cumulative Percent
BLS high budget or higher	$17,000 and over	43.9	100.0	$10,000 and over	38.8	100.0	$8,000 and over	11.9	100.0
BLS intermediate to high budget	$12,000–16,000	18.8	56.1	$ 7,000–9,999	19.5	61.2	$5,000–7,999	15.5	88.1
BLS low to intermediate budget	$ 8,000–11,999	16.9	37.3	$ 5,000–6,999	18.2	41.7	$3,500–4,999	17.8	72.6
Census near poverty to BLS low budget	$ 7,000–7,999	3.7	20.4	$ 4,000–4,999	7.8	23.5	$3,000–3,499	13.0	54.8
Census poverty level to near poverty	$ 6,000–6,999	3.5	16.7	$ 3,000–3,999	8.1	13.7	$2,500–2,999	12.6	91.8
Lower than the census poverty level	Less than $ 6,000	13.2	13.2	Less than $ 3,000	5.6	5.6	Less than $2,500	29.2	29.2

Source: R. C. Atchley, The Social Forces in Later Life. Belmont, California: Wadsworth Publishing Company, 1980, p. 112.

It is true that some elderly persons have an income flow from earnings, and some have an income flow from assets. However, these income flows are either restricted to a small portion of the elderly population or are inconsequential in their contributions to the income flow of most individuals. Eighty percent of the elderly manage to survive based directly on the income flow that they receive from Social Security (Atchley, 1980:3).

Health Science and the Older Adult

The older adult is a member of a highly heterogenous group of persons, particularly with regard to their health status. For example, 95 percent of all persons 65 years of age and older live in the community and not in institutional settings. Over 80 percent of these persons reported no limitations of mobility and no hospitalization in the past year. Consequently, the older adult is far healthier than many of the stereotypes would lead one to believe, regardless of the way in which health is defined (Harris, 1978:102).

According to the World Health Organization Charter (1946:1), health is defined as ". . . a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Atchley (1980:108) contends, however, that health should be conceptualized as stages on a continuum (see Table 22).

This section categorizes health statistics as either morbidity or mortality data. Morbidity data relate to the statistical reporting of acute and chronic health conditions, while mortality data relate to the statistical reporting of trends related to death figures.

TABLE 22

STAGES OF THE HEALTH CONTINUUM

Good Health							Poor Health
Absence of disease or impairment	Presence of a condition	Seeks treatment	Restricted activity	Restricted in major activity	Unable to engage in major activity	Institution-alized	Death

Source: R. C. Atchley. The Social Forces in Later Life. Belmont, California: Wadsworth Publishing Co., 1980, p. 109.

Morbidity and the Older Adult

Morbidity is said to be any departure from complete physical well-being or any departure from full health (Hendricks, 1981:483). Morbidity data can be categorized as either "prevalence" or "incidence" data. Prevalence refers to the total number of cases of a disease in existence at a specific time and in a specific area (Dorland's: 1255). Incidence refers to the number of new cases of a specific disease occurring during a specific period (Dorland's:770). Both prevalence and incidence data present health conditions for a specified population.

The term "health condition" may refer to "a defined departure from physical or mental well-being for a person" (Atchley, 1981:108), and it includes among other things, reactions to diseases. Disease is defined as a morbid process having a characteristic train of symptoms (Dorland's 1974:453). Morbid health conditions are categorized as either acute or chronic conditions. An acute disease, for example, is a disease that presents a short and relatively severe course of events (Dorland's 1974:34) while a chronic disease, on the other hand, is one that persists over a long period of time (Dorland's 1974:317). Both acute and chronic disease frequently require treatment. Treatment is an attempt to alleviate or mitigate or otherwise contain the conditions causing morbid symptoms in a person. Professional treatment is an attempt to alleviate, mitigate, or otherwise contain the conditions causing morbid symptoms in a person by a trained professional health care provider. There may or

may not be a cost involved when treatment is provided by a non-professional; however, there is almost always a cost involved when treatment is provided by a professional health care provider.

Many acute and chronic diseases create limitations and restrictions in activities for the older adult. Restrictions are categorized by severity. A "restriction of activity" is not as serious as a "restriction of major activity" when a person is said to be disabled, either partially or totally. Total disability often terminates in some type of institutionalization for the older person (Atchley, 1980:109).

The topics in this section on morbidity and the older adult are presented in the following order: health conditions and disease, acute and chronic disease, health limitations and disabilities, medical treatment, and, of course, cost.

General Health Status

There are many ways of indicating the general health status of persons who are 65 years of age or older. Three of the methods are of particular concern here: those utilizing data related to "expectation of life," "life expectancy at birth," and "percent of population reaching age 65." Data in these areas are reviewed in this section.

Additionally, the subjective assessments called "self-ratings of health status" are important in determining how the elderly themselves feel about their own health in comparison to other persons their own age. The findings in this area, which are also presented

in this section, do not agree with the general stereotype of elderly persons being sick, infirm and incapacitated old people.

Life Expectancy, Expectation of Life, and Percentage of Population Reaching Age Sixty-five

Life expectancy is commonly defined as the average number of years persons born in a certain year can be expected to live under the conditions prevailing that year (Atchley, 1980:10). "Expectation of life" utilizes the same general formula as that which produced the life expectancy data, but the object here is to compute statistically the additional years that a member of a cohort might have left to live. Of course, the expectation of life figures may increase, decrease or stay the same, depending on a wide range of intervening variables.

In the Life Statistics Table below (see Table 23), it can be seen that expectation of life figures in 1974 indicated that a 65-year-old person in general had 15.5 years left to live, using forecasted data based on probability. That same year, the white male had 13.4 years of life expectation, while the white female had 17.6 years of life expectation. Surprisingly, in this data set, the nonwhite male also had 13.4 years of life expectation in 1974 while the nonwhite female had 16.8 years of life expectation as opposed to 17.6 for the white female.

Life expectancy for the cohort born in 1974, as compared to the cohort born in 1900, has changed dramatically. The figures shown on the Life Statistics Table indicate 47.3 years of life expectancy for

TABLE 23

LIFE STATISTICS TABLE VALUES BY AGE, RACE, AND SEX:

UNITED STATES, 1974

	Total	White		All Others	
		Male	Female	Male	Female
Expectation of life (additional years) at age 65	15.5	13.4	17.6	13.4	16.8
Life expectancy at birth					
1900	47.3	46.6	48.7	32.5	33.5
1960	69.7	57.4	74.1	61.1	66.3
1970	70.9	68.0	75.6	61.3	69.4
1974	71.9	68.9	76.6	62.9	71.3
Percent of population reaching age 65					
1900-1902	40.9	39.2	43.8	19.0	22.0
1974	73.8	68.5	82.7	52.9	69.9

Source: Vital Statistics of the U. S., 1974, Vol. II, Section 5, "Life Tables" and Monthly Vital Statistics Report, "Provisional Statistics, Annual Summary for the U. S., 1975, Births, Deaths, Marriages, Divorces." Washington, D.C.: U. S. Government Printing Office, 1974-1975, pp. 1-220.

the cohort born in 1900 versus 71.9 for the cohort born in 1974. As for the percentage of the population reaching age 65, the figure for the cohort born in the three-year period from 1900 through 1902 is 40.9 percent; whereas for the cohort born in 1974, it is 73.8 percent.

Self-Assessment of Health Status

Approximately two out of three persons 65 years of age and older view themselves as being in good health, according to data collected by the National Center for Health Statistics (see Table 24). In fact, 68.9 percent of the older people assess their own health as either excellent or good when compared to others their own age (Kart, 1981:129).

Poor health is slightly more common among older men (9.4 percent) than it is among older women (8.0 percent). Also, as one would expect, the reporting of poor health increases as family income decreases. For example, less than 6 percent of the elderly with family incomes of $15,000 or more assessed their health as poor, while over 12 percent of those with family incomes of less than $5,000 did so. The reverse side of these figures is that over 9 out of 10 persons with incomes of $15,000 or more assessed their health as good or excellent, whereas approximately 6 out of 10 persons with incomes of less than $5,000 did so (Kart:129).

Harris (1978:102-103) summarizes this section on the general health status of the older adult:

TABLE 24

SELF-ASSESSMENT OF HEALTH STATUS BY AGE FOR SELECTED DEMOGRAPHIC CHARACTERISTICS, 1973 (PERCENTAGES)

	Total			Excellent			Good			Fair			Poor		
	17-44	45-64	65+	17-44	45-64	65+	17-44	45-64	65+	17-44	45-64	65+	17-44	45-64	65+
Total	100	100	100	52	35	29	39	42	39	7	16	22	1	6	9
Sex															
Male	100	100	100	57	38	31	35	40	38	6	15	21	1	6	10
Female	100	100	100	48	33	28	42	44	40	8	18	23	2	6	9
Race															
White	100	100	100	54	36	30	33	42	40	6	15	22	1	6	8
all other	100	100	100	38	24	20	45	39	33	13	26	28	3	10	18
Family Income															
under $5,000	100	100	100	40	18	25	42	35	38	13	28	25	4	18	11
5,000-9,999	100	100	100	48	29	31	42	44	39	9	20	22	2	6	7
10,000-14,999	100	100	100	54	37	36	39	45	38	6	14	18	1	4	8
15,000 & over	100	100	100	62	47	39	31	42	41	4	9	15	1	2	4

Source: Health: United States, 1975. National Center for Health Statistics. Washington, D.C.: U. S. Government Printing Office, 1975, pp. 437, 349, 551.

Improving the quality of health among the older population is a complex task. Solutions to health problems do not primarily lie in improving the health care system. Lifestyles--including pollution exposure, exercise patterns, nutrition, smoking behavior, alcohol consumption--can have a greater impact on health than the health care system itself. And the lifestyles of the older population are, in large part, a reflection of lifetime patterns of behavior and habit.

Acute and Chronic Conditions

Disease may be defined as a disorder of body functions. Both "disease" and "health conditions" may be categorized as either acute or chronic in nature.

Acute Conditions. Hendricks and Hendricks (1981:481) state that acute conditions are:

> . . . those illnesses marked by rapid onset, definite crisis and self-limiting aftermath. Usually they are brought on by exogenous factors which result in a traumatic course. The most frequent sufferers of acute illnesses are those in their first half of life.

For the purposes of this research, acute conditions will include only those diseases that restricts one's activities or which involve medical attention or treatment (Kimmel, 1980:335; Hess & Markson, 1980:91). Referencing incidence of acute conditions, the National Center for Health Statistics (Acute Conditions, 1974:396) has found that the quality of acute illnesses tends to decrease with increasing age. For example, in Table 25, the number of acute illnesses decreases from 372 cases per 100 persons for the "under 5" population to 198 cases per 100 persons for the "65+" population.

The data for acute conditions disaggregated by sex and age reveals that females in their subteen years suffered from fewer acute

TABLE 25

NUMBER OF ACUTE ILLNESSES PER 100 PERSONS PER YEAR, BY AGE

Age	Number of Illnesses
Under 5	372
5-14	290
15-24	239
25-44	204
45-64	144
65+	109

Source: Acute Conditions: Incidence and Associated Disability, United States, July 1971-June 1972. National Center for Health Statistics, Series 10, No. 88. Washington, D.C.: U. S. Government Printing Office, 1974. P. 22.

conditions than males of the same age. Beginning with the teenage years and continuing on through the entire life span, females experienced more acute conditions than their male counterpart (see Table 26).

Estes (1979:91) states:

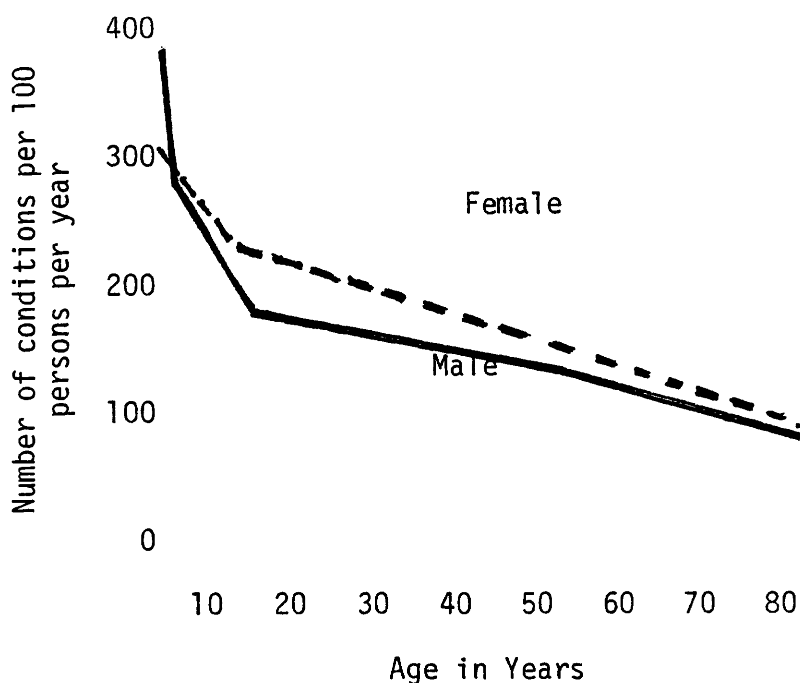
> As in all other age groups, the group of illnesses consisting of upper respiratory infections, influenza, and other respiratory ailments accounts for the majority of the episodes of acute illness and for most of the days of disability in the elderly. Injuries are the second most common cause of illness and days of disability. Contusions are the most frequent type of injury, followed by fractures, sprains, and dislocations. Digestive disorders are the third most frequent type of acute illness in the elderly. These three categories alone account for four-fifths of the acute illness problems of the elderly (fifty-eight, fourteen, and seven percent respectively).

The morbidity rate by condition and age is shown in Table 27. The general decrease in acute conditions with advancing age can be noted in all the data shown. Utilizing the same format for the major categories of acute conditions, the National Center for Health Statistics reported data for only the adult categories (see Table 28). The decreasing incidence of acute conditions is again readily apparent.

In summary, the elderly do experience a decreased incidence of acute conditions. The reasons for this occurrence are unclear. Possible reasons for this might be a much greater degree of immunity to common respiratory pathogens; a diminished level of awareness to details and to symptoms; or a diminished interest and concern in general which, along with other things, leads to less overt acknowledgement, or to less-conscious awareness of illness or the possibility of illness.

TABLE 26

INCIDENCE OF ACUTE CONDITIONS



Source: Vital and Health Statistics. National Center for Health Statistics. Series 10, No. 114. Washington, D.C.: U. S. Government Printing Office, 1977, p. 336.

TABLE 27

PERCENTAGE OF POPULATION WITH ACUTE CONDITIONS BY AGE, 1975

(BASED ON CIVILIAN NONINSTITUTIONALIZED POPULATION)

Condition	0-5	6-16	17-44	45+
Infective and parasitic	55.4	33.7	20.1	9.1
Respiratory				
Upper	142.9	81.3	51.7	29.3
Other	70.9	62.4	58.0	32.1
Digestive System	14.6	14.3	10.7	6.0
Injuries	49.5	43.9	38.7	24.6

Source: _Statistical Abstract of the United States, 1977_. National Center for Health Statistics. Washington, D.C.: U. S. Government Printing Office, p. 113.

TABLE 28

INCIDENCE OF SELECTED ACUTE CONDITIONS PER 100 PERSONS BY AGE, U. S., 1973

	Total	Male	Female
All Acute Conditions			
17-44	172.8	158.1	186.5
45-64	102.3	92.9	110.7
65+	88.2	85.8	89.9
Infective & Parasitic			
17-44	15.7	13.9	17.5
45-64	7.3	5.5	8.9
65+	4.9	a	a
Respiratory			
17-44	89.2	78.5	99.2
45-64	55.1	51.3	58.5
65+	42.1	41.9	42.2
Injuries			
17-44	33.8	43.0	25.4
56-64	20.0	20.0	19.
65+	19.4	17.7	20.6

[a]Figure does not meet NCH standards of reliability or precision

Source: Health: United States, 1975. National Center for Health Statistics. Washington, D.C.: U. S. Government Printing Office, p. 479, 555.

Chronic Conditions. Hendricks and Hendricks (1981:481) state that chronic conditions are:

> . . . lacking in specific etiology . . . [and] involve endogenous systemic disruptions which do not run a short-term course. Because they involve a number of bodily functions, the chronic diseases which older people suffer from most frequently are resistant to cure.

Hendricks and Hendricks (1981:195) add that:

> In contrast to acute conditions, chronic illnesses usually involve a number of bodily functions and cannot be attributed to a single cause, thereby confronting both the patient and the attending physician with a more obstinate problem. Another difference is that, unlike youthful illnesses, the pathological conditions of later years seem to be progressive, leading to increased vulnerability rather than protective resistance.

The incidence of chronic conditions increases with age; for example, there are 400 chronic conditions per one thousand population for persons under fifteen years of age. There are 4,000 chronic conditions per one thousand population for persons age sixty-five, and this figure does not include those over the age of sixty-five. On the other hand, while 86 percent of the elderly adults suffer from one or more chronic conditions, only about one half of all elderly adults are limited in any way by a chronic condition and only 14 percent are severely limited by chronic conditions. Even the majority of those persons who are severely limited by chronic conditions are not permanently bedridden (Estes, 1979:92).

Chronic conditions in the elderly can be positively correlated with various other social indices: for example, chronic conditions show a differential pattern in relationship to gender, income, color and education (see Table 29).

TABLE 29

PERCENT OF THE POPULATION 65 AND OVER WITH CHRONIC CONDITIONS AND WHO ARE UNABLE TO CARRY ON MAJOR ACTIVITY BY SELECTED CHARACTERISTICS: U. S., 1969-1970

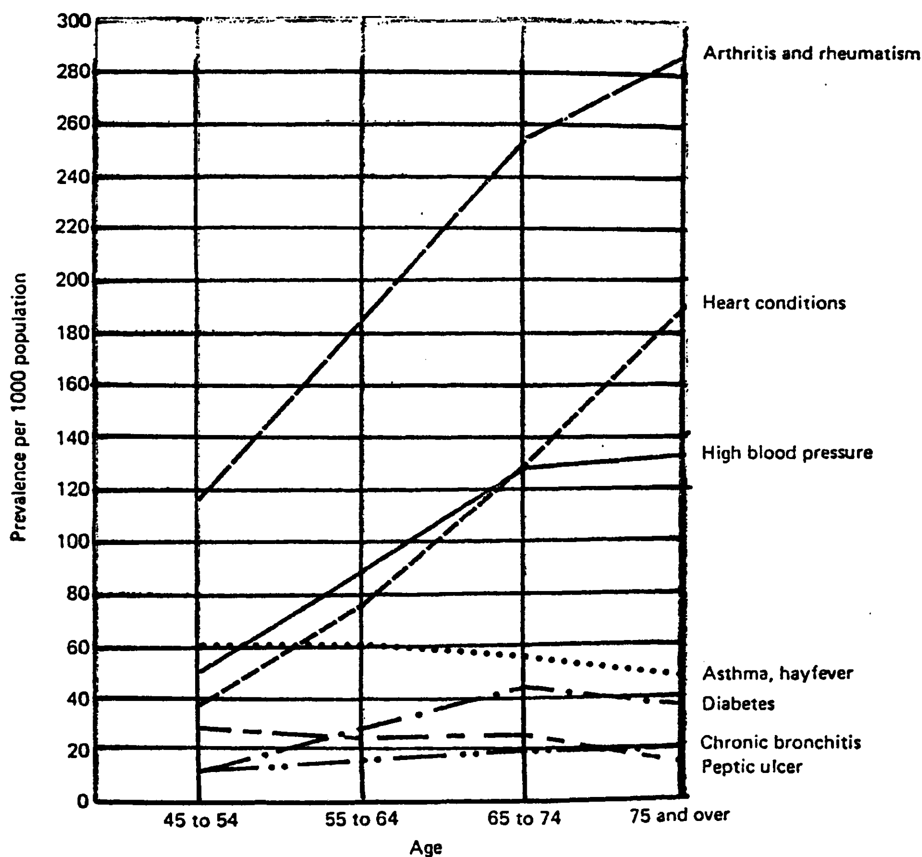
Sex	
Male	26.8
Female	8.5
Income	
Less than $3,000	19.0
$3,000–$4,999	16.0
$5,000–$6,999	14.9
$7,000–$9,999	14.7
$10,000–$14,999	13.9
$15,000 or more	13.8
Color	
White	15.5
All other	25.8
Education	
Less than 5 years	28.2
5–8 years	17.5
9–11 years	11.2
12 years	10.5
13–15 years	9.0

Source: Robert C. Atchely, The Social Forces in Later Life. Belmont California: Wadsworth Publishing Company, 1980, p. 113.

There is some shift in chronic condition patterns as cohorts age. Chronic conditions generally include: chronic physical aliments and disabilities, long-term mental illness, mental retardation, blindness and deafness, neurological disorders, diabetes, cancer, arthitis and rheumatic diseases, heart and circulatory disorders (Harris, 1978:109). From 1957 to 1959, the United States Health Survey completed by the National Center for Health Statistics indicates that arthritis and rheumatism, heart conditions, and high blood pressure (see Figure 8) were the three top chronic conditions for persons 45 years and older (Health Statistic,s 1960:35). Forty-five years of age was selected as a parameter for this study because "chronic conditions are seen with increased frequency in the middle years from 45 through 64" (Harris, 1978:109). It should be noted that chronic conditions do not suddenly begin to appear at age 65; rather, the incidence rate begins to increase appreciably in the mid-forties.

According to Harris (1978:109), the five most prevalent chronic conditions that affect the physical health of the elderly in 1975 were arthritis (38 percent), hearing impairment (29 percent), vision impairments (20 percent), hypertension (20 percent), and heart conditions (20 percent). For a comparison of the chronic conditions of the elderly to those of the younger cohorts, see Figure 2-8.

In summary, over half (575 per 1,000) of all persons 65 years of age or over suffer from some type of heart disease. Specifically, hypertensive heart disease and coronary artery disease are the two



Source: _Health Statistics, United States Health Survey, Series C,_ No. 4. Washington,D.C.: U. S. Government Printing Office, 1960, pp. 31, 35.

Figure 8

PREVALENCE OF SELECTED CHRONIC ILLNESSES AMONG PERSONS 45 AND OVER IN THE UNITED STATES, 1957 TO 1959

leading heart conditions covered by the generic term "heart disease" (Harris, 1978:92).

In Harris' data, arthritis is experienced by the elderly only slightly less often than heart disease (515 per 1000). Here again, there are several different conditions covered by one term. Osteoarthritis is the main disease in this group with over 90 percent of those with arthritis, suffering from osteroarthritis (Harris, 1978:92).

Heart conditions are found about equally among both sexes; whereas, arthritis, hypertension and visual disorders are experienced more by females and hearing losses, more by males. Additionally, it should be noted that prevalence rates for all known chronic conditions except ulcers are higher among the poor (Harris, 1978:92).

Health Limitations and Disability Days

Once a condition has been identified as acute or chronic, some type of treatment is usually initiated by the person himself or herself, or by a significant other. At this point, the activities of the person may or may not be restricted. If the activities of the person are restricted, the restriction may be either partial or total. If it is partial, it may be either a restriction or minor activities or a restriction of one or more major activities. Where this occurs, the person is said to be partially disabled. When a person cannot engage in a range of major activities considered vital for a person's independent life style, then the person is said to be totally disabled. Total disability usually leads directly to some type of institutionalization (Atchley, 1980:109).

Partially disabled persons may, if the presenting condition is lack of energy, select those activities that are to be suspended. However, illness and disease may force a person to suspend certain activities from their schedules, regardless of the importance of the activity to the person concerned.

Limitations are frequently a major consequence of both acute and chronic conditions experienced by the older adult. The limitations or restrictions vary from "restricted activity" to "bed disability." The relative importance of these two categories can be estimated from Table 30. Work loss days also indicate the relative seriousness of the restriction or limitation.

About forty percent of the group that is 65 years of age or older do suffer from some limitations of activities due to a chronic condition. Also, about forth percent of the members of this group suffer from partial limitations related to carrying out major activities related to independent living (see Figure 9).

General mobility of the elderly is an important activity supporting many of the other activities, both major and minor, related to independent living. Mobility, because of its vital nature, is usually reported on separately as an activity function.

Harris (1978:115) states:

> Most older persons--about 82%--do not suffer from serious handicaps in mobility. But the extent to which the elderly are limited in this regard is substantial when compared to other segments of the population. Almost 18 percent of the noninstitutionalized elderly report some limitation of mobility, whereas less than one percent of the 17-44 age group and less than five percent of the 45-64 age group experience health-related mobility limitations.

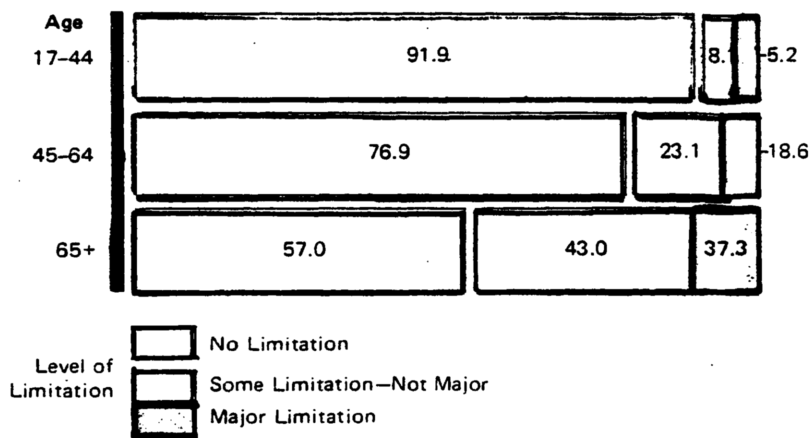
TABLE 30

DAYS OF DISABILITY PER PERSON PER YEAR BY SEX AND AGE, 1975

	Restricted Activity Days	Bed Disability Days	Work Loss Days
Total			
All ages	17.9	6.6	5.2
65+	38.4	12.9	4.3
Male			
All ages	15.6	5.4	4.9
65+	34.3	12.2	5.1
Female			
All ages	20.0	7.6	5.7
65+	41.4	13.4	a

[a]Less than 1 day

Source: Current Estimates from the Health Interview Survey: U. S., 1975. National Center for Health Statistics, Series 10, No. 115. Washington, D.C. U. S. Government Printing Office, 1975, p. 119.



Source: Current Estimates from the Health Interview Survey, 1977. National Center for Health Statistics, Series 10, No. 126, Washington, D.C.: U. S. Government Printing Office, 1978, p. 24.

Figure 9

PERCENTAGE OF ADULTS WITH VARIOUS DEGREES OF ACTIVITY LIMITATIONS DUE TO CHRONIC CONDITIONS

The National Center for Health Statistics has presented data for 1975 showing mobility limitations in relationship to gender, age, color and family income (see Table 31). This permits comparisons among all the adult age groups, as well as comparisons among a series of important intervening variables.

In summary, over half of the elderly do not have any type of activity limitations related to health conditions. Only slightly over one out of three persons have a major limitation. Older females have more limitations than do older males; however, it should be noted that females represent an older subsample of the elderly population and are, consequently, somewhat more likely to have mobility limitations than males. Nonwhites and the persons in the lower income categories tend to have the greatest mobility limitations in general.

Utilization of Health Services

Improved techniques and medical technology have resulted in a larger proportion of the population living to 65 years of age and beyond. The threshold for the survival of the fittest has been lowered considerably. Consequently, this may lead to a less healthy population of very old people (Kimmel, 1980:341). Whether this is correct or not, the elderly do utilize health services to a greater degree than do the members of the younger cohorts.

The use of health services is based on three factors: (1) the predisposing factors, including social structure variables (race, religion, including available family income); (2) accessibility of

TABLE 31

PERCENTAGE OF PERSONS WITH MOBILITY LIMITATION ACCORDING TO SELECTED DEMOGRAPHIC CHARACTERISTICS, UNITED STATES, 1972--BY AGE

Sex and Age	Total Population	Persons with No Chronic Conditions	Persons with 1 Chronic Condition or More					
			Total	With No Limitation of Activity	With Limitation But Not in Major Activity[a]	With Limitation in Amount or Kind of Major Activity[a]	Unable to Carry on Major Activity[a]	Total with Some Limitation
Both Sexes								
All ages	100.0	50.5	49.5	38.0	2.9	6.4	2.1	11.4
Under 17 years	100.0	77.2	22.8	20.9	1.0	0.7	0.2	1.9
17–44 years	100.0	45.9	54.1	46.7	2.7	4.1	0.6	7.4
45–64 years	100.0	28.9	71.1	51.8	5.1	11.4	2.8	19.3
65 years and over	100.0	14.4	85.6	39.6	6.5	25.7	13.8	46.0
Male								
All ages	100.0	51.8	48.2	36.1	2.5	6.5	3.1	12.1
Under 17 years	100.0	75.8	24.2	22.1	1.1	0.8	0.2	2.1
17–44 years	100.0	47.4	52.6	44.7	2.5	4.6	0.9	8.0
45–64 years	100.0	30.5	69.5	48.7	4.4	11.9	4.5	20.8
65 years and over	100.0	15.6	84.4	31.4	4.6	26.8	21.6	53.0
Female								
All ages	100.0	49.3	50.7	39.9	3.3	6.3	1.2	10.8
Under 17 years	100.0	78.6	21.4	19.5	1.0	0.7	0.1	1.8
17–44 years	100.0	44.7	55.3	48.5	2.9	3.6	0.4	6.9
45–64 years	100.0	27.5	72.5	54.7	5.7	10.9	1.2	17.8
65 years and over	100.0	13.5	86.5	45.9	8.0	24.9	7.7	40.6

Source: R. C. Atchley. The Social Forces in Later Life. Belmont, California. Wadsworth Publishing Company, 1980, p. 111.

services; and (3) need factors, which include symptoms, disability and the individuals' response to illness.

In this subsection, the utilization of health services by the older adult is reviewed in the following order: visits to physicians, short-term hospitalization, long-term institutional care and home care.

Visits to Physicians. A review of the professional literature reveals several methods of assessing the frequency of physician-patient contact for the elderly cohort. The main methods are based on the number of visits per person per year; the percent of older persons who saw a physician during a specified time period; and last, a comparison of the percentage of older persons with the percentage of total physicians visits assigned to this group. Regardless of the method used, the results are approximately the same. Elderly persons see physicians slightly more frequently than younger persons do (Harris, 1978:121). In view of the increased incidence of chronic illness experienced by the elderly, one might expect the elderly persons to see physicians at a much higher rate.

The average number of physician visits per year, for the population as a whole was 5.1 visits in 1975. For the elderly group, the average number of physician visits per year for the same period was 6.6 visits. Surprisingly, the group 65 to 75 and the group 75 years and older both averaged 6.6 physician visits, also (Harris, 1978:122).

The elderly comprised 10 percent of the total population in 1975 and accounted for 13 percent of the visits to physicians (Harris, 1978: 122). This segment of the population apparently does not utilize

physicians' services in accordance with their needs. For example, a National Center for Health Statistics study showed that 86 percent of the total population had visited a physician during the past twelve months; where as only 85 percent of the elderly had done so (see Table 32).

Utilizing data from physicians' records rather than from personal interviews, the National Ambulatory Medical Case Survey of 1973-1974 (1975) found that the elderly accounted for 15.5 percent of the office visits to physicians, the lowest percentage for any age group except the 15-24 age group with 15.4 percent. On the other hand, the members of the elderly group did log more physician visits per person per year than did the members of any other age group--4.9 visits versus 3.1 visits for all age groups (National Ambulatory, 1975:122). The records indicate that three fourths of all physician visits by the elderly take place in the physician's office. For members of the minority groups, the clinic is an important source of physician contact; 17 percent of the nonwhite elderly visited physicians in clinics (Harris, 1978:124).

Elderly women visited physicians more than elderly men at a rate of 6.8 to 6.4 annual visits (see Table 33). According to Nathanson (1975:57) this is because of three factors:

1. Women need medical services more frequently than men because it is culturally more acceptable for them to be ill.
2. A woman's role is relatively undemanding, thus reporting illness and visiting the doctor is more compatible with

TABLE 32

PERCENT DISTRIBUTION OF PERSONS BY TIME INTERVAL SINCE LAST PHYSICIAN VISIT, BY AGE AND SEX, U. S., 1975

		Time Interval Since Last Physician Visit						
	Total	under 6 mo.	6-11 mo.	1 yr.	2-4 yrs.	5+ yrs.	never	unknown
Total								
All ages	100	59.4	15.8	10.8	9.5	3.6	.2	.7
65+ yrs.	100	68.6	10.1	6.1	8.2	6.5		.4
Male								
all ages	100	53.9	16.6	12.3	11.7	4.4	.3	.8
65+ yrs.	100	65.6	10.3	6.5	9.6	7.4		.5
Female								
all ages	100	64.6	15.0	9.4	7.4	2.9	.2	.5
65+ yrs.	100	70.8	10.0	5.8	7.3	5.8		.3

Source: Current Estimates from the Health Interview Survey: U. S., 1975, National Center for Statistics, Series 10, No. 115. Washington, D.C.: U. S. Government Printing Office, 1975, p. 30.

TABLE 33

PHYSICIAN VISITS PER PERSON PER YEAR, ACCORDING TO AGE, SEX, COLOR AND FAMILY INCOME: UNITED STATES, 1975

Sex, Color, Family Income	Physicians Visits Per Person Per Year				
	All Ages	Under 15 Years	15-44 Years	45-65 Years	65 Yrs. and Over
Total	5.1	4.4	4.8	5.6	6.6
Sex					
Male	4.3	4.7	3.5	4.7	6.4
Female	5.7	4.1	6.0	6.5	6.8
Color					
White	5.1	4.5	4.8	5.6	6.5
All other	4.7	2.8	4.5	6.2	5.9
Family income*					
Less than $5,000	6.0	4.7	5.7	7.4	6.5
$5,000-$9,999	5.2	4.0	5.0	5.8	7.2
$10,000-$14,999	4.8	4.4	4.5	5.5	6.9
$15,000 or more	4.9	4.7	4.7	5.3	6.4

*Excludes unknown family income

Source: C. S. Kart. The Realities of Aging. Boston: Allyn and Bacon, Inc., 1981, p. 131.

her other role responsibilities than is the case for men.

3. Women's assigned social roles are in fact more stressful than those of men--consequently, they have more real illness and need more care.

As Nathanson quickly points out, insufficient data are available to evaluate the merits of these particular explanations so they are suggestive at best.

Looking to the future, from 1978 to 2003, total physician visits for persons of all ages are forecasted to increase from 1,072,000,000 to 1,358,000,000 visits, respectively. The 65-and-over group accounted for 85 percent of these visits in 1978 and are projected to account for 84 percent of the visits in 2003; that is, there is no appreciable change in the rate of physician visits forecasted for the elderly group (Van Nostrand, 1980:no page).

Short-term Hospitalization--Before presenting the data relating to the short-term hospitalization of the elderly, it should be emphasized that in 1975, 82.6 percent of the elderly had no hospitalization compared to 89.4 percent of the total population. Thus about one in six elderly persons and one in ten persons in the younger cohorts required hospitalization at least once that year (Current Estimates, 1977:140).

A review of the data in Table 34 reveals that the rate of hospitalization, the number of days of hospitalization, and the average length of stay per hospital patient all increase with increasing age. Breaking the discharge and duration-of-stay data

TABLE 34

RATES OF DISCHARGE FROM SHORT-STAY HOSPITALS AND AVERAGE DURATION OF STAY, BY AGE AND SEX, UNITED STATES, 1968-1969

	Age			
	Under 17	17-44	45-64	65 and Over
Discharge rates (per 1,000 persons)				
Total	62.6	147.4	143.1	232.6
Male	68.4	86.8	140.3	242.6
Female	56.6	201.5	145.6	225.0
Duration of stay (in days)				
Total	5.6	6.8	11.3	15.3
Male	5.5	9.5	12.4	15.4
Female	5.7	5.7	10.3	15.2

Source: R. C. Atchley. _The Social Forces in Later Life_. Belmont, California: Wadsworth Publishing Company, 1980, p. 121.

down by age and sex reveal that elderly males enter the hospital more frequently and stay longer than do elderly females. It should be remembered that elderly females have more physician visits per year than do the elderly males, which may relate to the fewer short-term hospital stays.

Short-term hospital discharge rates for both the elderly male and female increased rapidly after the initiation of the Medicare program in July 1966. For example, the elderly accounted for 22.5 percent or 359.3 per 1,000 patients discharged in 1975 (Utilization, 1975:127) (see Table 35).

According to Van Nostrand (Van Nostrand, 1980:no page) the elderly accounted for 63 percent of the total 274 million short-stay hospital care days in 1978. This percentage is projected to remain approximately the same in 2003 but the total short-stay hospital care days for the elderly alone will rise to 372 million (see Figure 10).

In summary, older persons are both more likely to go to a short-stay hospital and to stay there longer than members of younger age groups. From 1965 to June 1966, however, 87 percent of the 17.5 million older adults in the United States had no hospital episodes (Atchley, 1980:121).

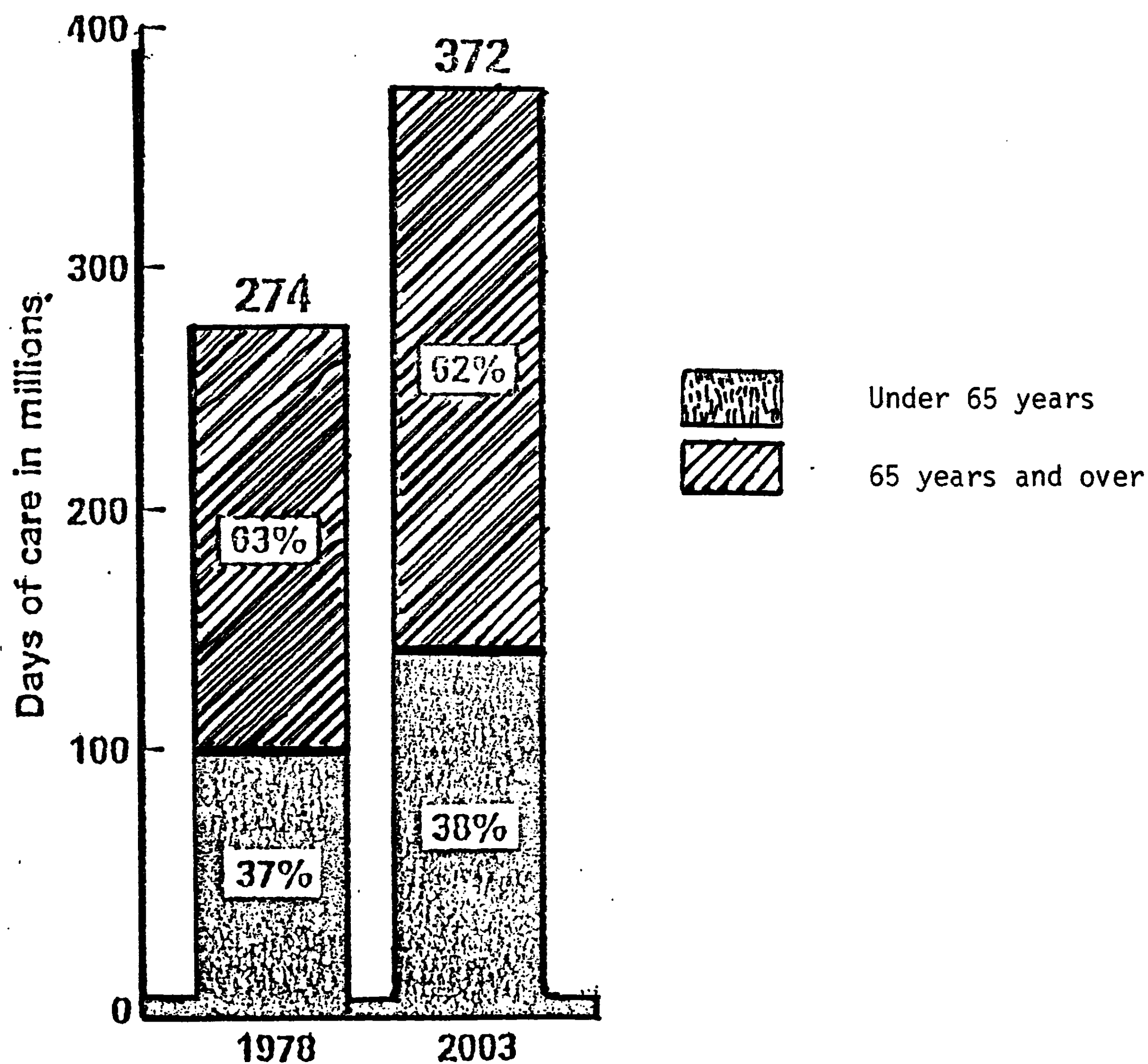
<u>Long-term Care</u>. Approximately 5 percent of the elderly reside in long-term care facilities. Nursing homes are the main type of long-term care facility to be considered here as they are the most important type of facility in reference to both census figures and cost figures.

TABLE 35

PERCENT DISTRIBUTION AND RATE OF PATIENT-DISCHARGE FROM SHORT-STAY HOSPITALS, U. S., 1975

	Discharged Patients		Days of Care		Average
	Percent	rate per 1,000	Percent	rate per 1,000	Length (days)
Total, all ages....	100.0	162.8	100.0	1,254.9	7.7
55-64 years......	12.3	214.8	15.5	2,083.5	9.7
65 years & over..	22.5	359.3	33.8	4,165.9	11.6
65-74 years....	11.9	299.9	17.1	3,323.4	11.1
75 and over....	10.6	462.6	16.7	5,631.7	12.2

Source: "Utilization of Short-Stay Hospitals: Annual Summary for the U. S., 1975." *Vital and Health Statistics*, Series 13, No. 31. Washington, D.C.: U. S. Government Printing Office, 1975, p. 127.



Short-stay Hospital Days

Source: Joan F. Van Nostrand. Information on Long-term Care: Compendium of Current Data and Projections. The Mini-Whitehouse Conference on Long-term Care. Washington, D.C.: U. S. Government Printing Office, 1980.

FIGURE 10

PROJECTION OF SHORT-STAY HOSPITAL DAYS

Long-term care for the elderly is provided by a number of institutions. The three main categories of long-term care institutions are the nursing home, the hospital, and what is called the "residential care bed," which is located in specialized residential units. Sixty-nine percent of the long-term care beds are located in nursing homes, 16 percent are located in hospitals, and 15 percent are located in residential units (Van Nostrand, 1980:no page).

1. Nursing Homes. As the elderly continue to age, their limitations increase; that is, increasing numbers are either partially or fully disabled. The nursing home in recent years has become the final home for many of the elderly in the United States. Harris (1978:128) states:

> In the last 25 years, there has been a major shift in the pattern of institutionalizing the elderly. In 1950, 37 percent of the older institutionalized population were residents of mental hospitals. By 1970, this figure had dropped to eight percent, with 60 percent in nursing homes. Between 1960 and 1976, there was a 245 percent increase in the number of nursing-home residents, in large part a reflection of the increasing tendency to place the older "senile" population in nursing homes rather than in mental institutions. Of the residents of nursing homes in 1975, approximately 38 percent lived in private residences immediately prior to institutionalization, and 35 percent were patients in short-stay hospitals.

Nursing home beds account for approximately 70 percent of all long-term care beds; consequently, the nursing home is considered to be the most important of the long-term care facilities for the elderly. Approximately 5 percent (about one million people) of the elderly population reside in nursing homes (Van Nostrand, 1980:1).

The residents are mainly white (94%), widowed (64%), and females (70%) (see Table 36). Seventy-four percent of nursing homes

TABLE 36

NUMBER AND PERCENTAGE DISTRIBUTION OF NURSING HOME RESIDENTS BY AGE ACCORDING TO SELECTED DEMOGRAPHIC CHARACTERISTICS, U. S., 1973-1974

	Total	Under 65 yrs.	65-74 yrs.	75-84 yrs.	85+ yrs.
Number of residents	1,074,500	114,200	162,900	384,400	413,000
	Percentage distribution				
Total	100.	100.	100.	100.	100.
Sex					
Male	29.6	45.8	40.0	26.6	23.8
Female	70.4	54.2	60.0	73.4	76.2
Marital Status					
Married	12.4	14.5	18.4	14.2	7.8
Widowed	63.9	17.5	46.1	68.4	79.5
Divorced/Separated	4.7	15.6	9.9	3.0	1.2
Never married	19.0	52.4	25.6	14.3	11.5
Race					
White	93.9	86.7	90.2	95.1	96.3
All other	6.1	13.3	9.8	4.9	3.7

Source: "Nursing Home Survey, 1973-74. Health: United States, 1975. National Center for Health Statistics. Unpublished Provisional Data, 1974, no page.

residents are 75 years of age or older; 19 percent are 86 years of age or older and suffer from a series of conditions such as hardening of the arteries (23%), senility (14%), strokes (11%), and mental disorders (10%) (Nursing Home, 1970:no page).

In summary, nursing homes are not the only long-term care institution for the elderly. However, nursing home beds do comprise approximately 70 percent of the total beds reserved for elderly long-term care patients. While hospitals and residential units each comprise only approximately 15 percent of the total beds reserved for the elderly long-term care patient (Van Nostrand, 1980:no page).

2. Home Care. Many older adults receive care at home. Much of this is general personal care such as help in bathing, cutting of toenails, and in moving about. Of course, much of this personal care can be categorized as personal health care, such as changing bandages, giving injections, and various other medical treatment assists (see Table 37) (Atchley, 1980:120).

In 80 percent of the cases, home care is provided by a relative living in the household. Approximately 80 percent of home health care provided in the period from July 1966 to June 1968 had been provided for a period of at least a year or longer; and approximately one third of this care was 100 percent, "round-the-clock" care (Atchley, 1980:120).

Cost of Health Care

In 1975, the total expenditure for personal health care in the United States exceeded 100 billion dollars (103.2 billion dollars)

TABLE 37

NUMBER OF PERSONS 55 YEARS AND OVER RECEIVING CARE AT HOME AND PERCENT OF TOTAL BY AGE AND SEX, ACCORDING TO SPECIFIC CARE PROVIDED: UNITED STATES, JULY 1966-JUNE 1968

Specific Care Provided	Total Persons Receiving Care	Age			Sex	
		55–64 Years	65–74 Years	75 Years and Over	Male	Female
			Number in thousands			
All care provided	1,747	363	409	886	694	1,053
			Percent of total			
Moving about	44.8	41.0	41.1	48.5	36.7	50.1
Dressing	53.5	56.2	53.3	52.5	61.2	48.4
Bathing	60.7	52.1	55.1	67.3	67.9	56.0
Eating	18.8	15.2	16.8	21.3	18.0	19.2
Changing bandages	6.6	*	7.0	6.5	8.1	5.7
Injections	14.1	16.0	17.4	11.5	12.7	15.1
Other medical treatment	10.4	8.8	11.6	10.4	11.0	10.1
Changing bed position	13.2	11.3	14.2	13.5	12.8	13.5
Physical therapy	10.5	11.0	12.2	9.3	10.7	10.4
Cutting toenails	59.3	50.4	56.3	64.4	61.2	58.0
All other care	9.4	9.1	9.8	9.3	8.8	9.8

Source: R. C. Atchley. The Social Forces in Later Life. Belmont, Calif.: Wadsworth Publishing Company, 1980, p. 62.

Approximately one third of this 1975 budget was spent on providing health care for the elderly. The greater expense is related primarily to two main facts: the elderly suffer from more chronic conditions than do members of younger cohorts, and the hospital is the setting for the treatment of many of these chronic health problems (Harris, 1978:130).

Average Health Care Costs. Harris (1978:130) states:

> Personal health care expenditures per capita for the total population was $475 in fiscal year 1975. For persons 65 years and over, the average health bill was $1,360, more than six times that of the under-19 age group and almost three times as large as the intermediate age group (19-64 years). For the younger population, the average cost of health care increased two and a half times since 1966 (the year Medicare and Medicaid began operating); for the elderly, it more than tripled. Between 1974 and 1975, per capita increases in health care expenses rose higher for the aged than for any other age group in the population: a 15 percent increase for total health care cost, compared to an 18 percent increase for the elderly.

Mueller and Gibson (1976:19) present a percentage distribution table for personal health care expenditures by age for fiscal year 1975. As can be seen in Table 38, the elderly pay 29 percent of the cost of their medical treatment and third-party payments account for 71 percent of these costs.

It should be noted that dental services, eye glasses, drugs and other health appliances are not covered by Medicare and are frequently not covered by private insurance programs either. These expenses, while only a small part of the total, can place an additional burden on the financial resources of the elderly if these utilities are procured, which in many cases of considerable need they are not (see Table 39).

TABLE 38

PERSONAL HEALTH CARE EXPENDITURES BY AGE, FISCAL YEAR 1975

	Percentage Distribution				
	Health Expenditures	Population	Average Health Care Bill	Direct Payments Average Percent	Third Party Payments--Percent
All ages	100	100	$ 476	33	67
Under 19 years	14.9	34.7	212	34	66
19 - 64 years	55.6	55.3	472		
65 + years	29.4	10.0	1,360	29	71

Source: M. S. Mueller and R. M. Gibson, "Age Differences in Health Care Spending, Fiscal Year 1975." Social Security Bulletin, 39 (June 1976):20.

TABLE 39

PERCENT DISTRIBUTION OF PERSONAL HEALTH CARE EXPENDITURES FOR PERSONS 65 YEARS AND OVER, BY SOURCE OF FUNDS ACCORDING TO TYPE OF EXPENDITURE: UNITED STATES, FISCAL YEAR 1975[a]

Type of Expenditure	All Sources	Private	Public		
			Total	Medicare	Other
Total	100.0 ($30,383)	34.4 ($10,466)	65.6 ($19,917)	42.0 ($12,749)	23.6 ($7,169)
Hospital care	100.0 ($13,467)	10.2	89.8	72.2	17.6
Physician services	100.0 ($4,862)	40.9	59.1	54.1	5.1
Dentist services	100.0 ($540)	92.9	7.1	--	7.1
Other professional services	100.0 ($441)	49.8	50.2	38.0	12.2
Drugs and drug sundries	100.0 ($2,629)	86.9	13.1	--	13.1
Eyeglasses and appliances	100.0 ($506)	98.4	1.6	—	1.6
Nursing home care	100.0 ($7,650)	46.7	53.3	3.1	50.3
Other health services	100.0 ($288)	8.2	91.8	—	91.8

[a]Dollar amounts in million.

Source: M. S. Mueller. "Age Differences in Health Care Spending, Fiscal Year 1975." Social Security Bulletin 39 (June 1976):181.

Type of Care and Source of Payment. In 1975, hospital care accounted for 44 percent of all personal health care expenditures for the aged, or an average per capita expenditure of $602.89. Medicare paid approximately 70 percent of this bill, and various other public funding accounted for approximately 20 percent. The remaining 10 percent was paid either by private insurance or by private funds (Kart, 1981:20). Hospital care, nursing home care and physicians' services accounted for almost 86 percent of the total 30 million dollars spent on personal health care for the elderly in 1975 (see Table 40).

According to Van Nostrand (1980, no page), per capita expenditures for personal health care for the elderly for 1978 was $2,026. Of the total expenditures for this age group, hospital care accounted for 43 percent; nursing homes, 26 percent; professional services, 23 percent; and all other health services, 8 percent (see Figure 11).

In 1978, Medicare represented almost half of the total health cost provided for the elderly. The sources of payment for this care were as follows: Medicate (44%), private sources (36%), Medicaid (13%) and other public programs 6%) (see Figure 12).

In summary, by 1979, the total expenditure for personal health care in the United States had grown to 212 billion dollars. The elderly who constituted 11 percent of the population during this period accounted for approximately 30 percent of the expenditures in this area. The per capita expenditure for the 65-and-over age group was $2,258, almost three times that of persons under 65 years of age. Since 1976, the elderly have been paying a rapidly growing

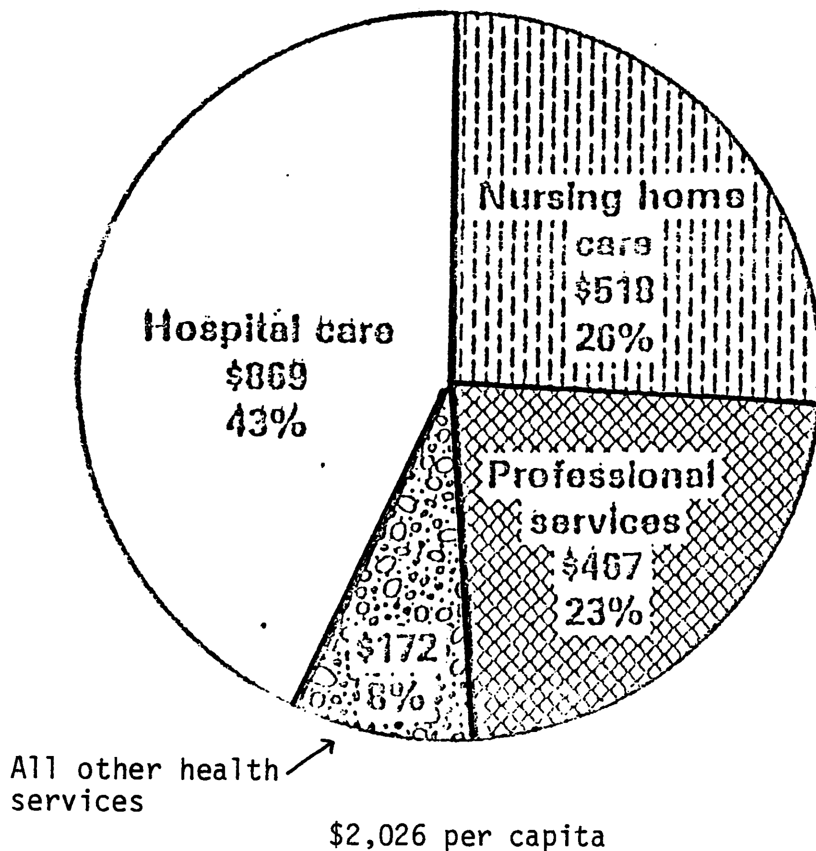
TABLE 40

PER CAPITA PERSONAL HEALTH CARE EXPENDITURES ACCORDING TO AGE, SOURCE OF FUNDS, AND TYPE OF EXPENDITURE: UNITED STATES, FISCAL YEAR 1975. DATA COMPILED FROM GOVERNMENT AND PRIVATE SOURCES

	All Ages			*Under 19 Years*			*19–64 Years*			*65 Years and Over*		
Type of Expenditure	*All Sources*	*Private*	*Public*	*All Sources*	*Private*	*Public*	*All Sources*	*Private*	*Public*	*All Sources*	*Private*	*Public*
Total	$476.40	$287.48	$188.92	$212.14	$160.52	$51.62	$471.88	$330.03	$141.85	$1,360.16	$468.53	$891.63
Hospital care	215.12	96.74	118.38	71.23	42.17	29.05	229.82	135.74	94.07	602.89	61.75	541.14
Physician services	102.02	74.99	27.03	69.99	61.02	8.98	99.91	80.77	19.14	217.66	88.96	128.69
Dentist services	34.62	32.71	1.92	21.27	19.10	2.17	44.51	42.71	1.80	24.17	22.45	1.72
Other professional services	9.69	7.35	2.35	6.36	5.21	1.15	9.84	8.17	1.67	19.74	9.83	9.91
Drugs and drug sundries	48.93	44.76	4.18	27.73	26.07	1.66	48.96	45.35	3.62	117.68	102.30	15.38
Eyeglasses and appliances	10.62	10.15	0.47	5.23	5.03	0.20	11.63	10.97	0.65	22.65	22.29	0.36
Nursing home care	41.55	17.54	24.01	3.10	1.91	1.19	9.25	0.73	8.52	342.47	159.88	182.58
Other health services	13.85	3.26	10.59	7.23	0.01	7.22	17.98	5.61	12.37	12.89	1.05	11.84

Source: M. S. Mueller. "Age Differences in Health Care Spending, Fiscal Year 1975. Social Security Bulletin 39 (June 1976):18.

Type of Care



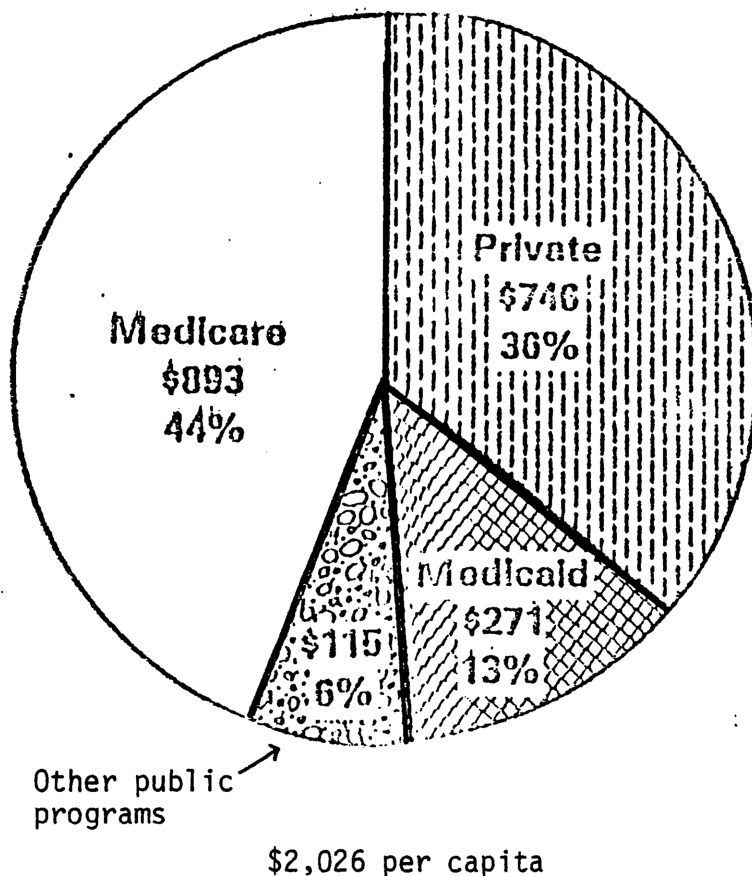
Source: J. F. Van Nostrand. Information on Long-Term Care: Compendium of Current Data and Projections. The Mini-White House Conference on Long-Term Care. Washington, D.C.: U. S. Government Printing Office, 1980, no page.

FIGURE 11

PER CAPITA HEALTH CARE EXPENDITURES FOR THE ELDERLY BY TYPE OF PAYMENT:

UNITED STATES, 1978

Source of Payment



Source: J. F. Van Nostrand. Information on Long-Term Care: Compendium of Current Data and Projections. The Mini-White House Conference on Long-Term Care. Washington, D.C.: U. S. Government Printing Office, 1980, no page.

FIGURE 12

PER CAPITA HEALTH CARE EXPENDITURES FOR THE ELDERLY BY SOURCE OF CARE: UNITED STATES, 1978

larger proportion of their own health costs out of what, many times, are their own meager resources. For 1979, the elderly paid 43 percent of the total costs of the health services provided for them (Health, 1981:1).

Mortality in the United States

This section on mortality and the elderly first reviews the causes of death for persons of all ages in the United States. Then the causes of death of the older adult is presented.

Leading Causes of Death for All Ages. In the United States the population has aged primarily because of the reduction of infant and early-life mortality, which has permitted more people to live to the age of 65 years and beyond. The reduction of infectious diseases is the main cause of this reduced mortality rate (Mortality Trends, 1974:60).

In 1900, the leading cause of death was pneumonia and influenza, which in the present data were reported together as one item, followed by tuberculosis, and then by diarrhea and enteritis. All of these are infectious diseases; in fact, 57 percent of the deaths attributed to the ten leading causes of death in 1900 were categorized as infectious diseases. In 1969, however, 85 percent of the deaths were attributed to chronic non-infectious diseases (Decker, 1980:60-61).

Leading Causes of Death for the Elderly. The leading causes of death for the elderly are very similar to the leading causes of death for the general population. For both groups, the leading causes

of death are heart disease, cancer and cerebrovascular diseases (see Table 41). The rates of these diseases are much higher, of course, for the elderly (see Table 42).

Political Science and the Older Adult

The literature related to the older adults as political actor should logically commence with a review of the literature related to the first phase of this process, the phase of socialization theory. This establishes a foundation for investigating both the strength and the type of political party affiliations made by older adults. A review of voting characteristics for this age group is then presented. This investigation is then widened to include political participation of other types, besides the voting act itself. Following the section on political participation, the arguments for and against the older persons becoming a subculture or a social movement are reviewed. This is followed by the last two theoretical constructs to be presented in this section on the survey of the literature of older adults as political beings. These are Rostow's (Rostow, 1974) "no-norm theory" of old age and Trela's (Trela, 1972) "status inconsistency theory" applied to old age.

Socialization Theory and Research

Conscious political ideation commences at some specific point in time with each individual. There is ample evidence on hand to lead one to believe that this process begins quite early in childhood in most cases. In fact, this assumption is one of the "givens" in

TABLE 41

DEATH RATES, BY SELECTED CAUSES AND AGE GROUPS, 1976

Cause of Death	Age Group (Deaths per 100,000)											
	Total	< 1 yr.	1–4	5–14	15–24	23–34	35–44	45–54	55–64	65–74	75–84	85+
Malignant neoplasms	175.8	3.2	5.3	5.0	6.5	14.5	51.5	182.0	438.4	786.3	1248.6	1441.5
Diabetes mellitus	16.1	.3	.1	.1	.4	1.8	3.9	9.8	28.4	70.0	155.8	219.2
Heart diseases	337.2	23.1	1.8	.9	2.6	8.5	50.8	199.8	552.4	1286.9	3263.7	7384.3
Cerebrovascular	87.9	4.4	.7	.6	1.2	3.4	11.5	31.4	85.8	280.1	1014.0	2586.8
Arteriosclerosis	12.3	.9	0	0	0	0	.2	.9	5.2	25.8	152.5	714.3
Pneumonia and flu	28.8	64.8	3.9	1.0	1.5	2.4	5.4	11.6	26.3	70.1	289.3	959.2
Bronchitus, emphysema and asthma	11.4	2.3	.5	.2	.2	.5	1.3	6.0	23.0	60.7	101.4	108.5
Cirrhosis of liver	14.7	1.1	.1	0	.3	3.7	16.9	35.0	47.6	42.6	29.3	18.0
Diseases of infancy	11.6	818.5	.1	0	0	0	0	0	0	0	0	0
Accidents	46.9	41.4	27.9	17.0	59.9	43.5	37.1	39.9	47.7	62.2	134.5	306.7
Suicide	12.5	0	0	.4	11.7	15.9	16.3	19.2	20.0	19.5	20.8	18.9
Homicide	9.1	5.6	2.5	1.1	12.4	16.5	14.3	10.0	7.3	5.3	5.3	4.9

Source: Advance Report: Final Mortality Statistics, 1976. Department of Health, Education, and Welfare, 78-1120. Washington, D.C.: Department of Health, Education, and Welfare Publication, 1978

TABLE 42

RANK ORDER OF CAUSES OF DEATH FOR MALES AND FEMALES OVER AGE 65 IN THE UNITED STATES, 1968

Rank	*Males*	*Females*
1	Diseases of the heart	Diseases of the heart
2	Cancer	Cerebrovascular diseases
3	Cerebrovascular diseases	Cancer
4	Influenza and pneumonia	Influenza and pneumonia
5	Bronchitis, emphysema, and asthma	Arteriosclerosis
6	Accidents	Diabetes mellitus
7	Arteriosclerosis	Accidents
8	Diabetes mellitus	Bronchitis, emphysema, and asthma
9	Cirrhosis of the liver	Kidney infections
10	Peptic ulcer	Hypertension

Source: Health in the Later Years of Life. National Center for Health Statistics. Washington, D.C.: U. S. Government Printing Office, 1971, p. 62.

political science studies dealing with political socialization (Searing, Schwartz & Lind, 1973:415).

Searing, Schwartz and Lind (1973:415-433) present what is probably the best recent survey of this socialization literature. They modify the original socialization argument in an interesting and valid manner and then undertake a rigorous research study to substantiate the validity of this new model.

In their review of the literature, they find that there are two specific conceptual models that appear with great regularity throughout the political science literature related to political socialization. These are the "allocative politics model" and the "systems persistence model." The first model is based on the primacy principle, which states that childhood learning is enduring throughout life. The "systems persistence model" is based on the structuring principle, which states that basic orientations learned in childhood tend to structure the later learning of specific issue beliefs.

According to Searing, Schwartz and Lind, to achieve even a rudimentary political socialization pattern, the elements of value, attitude and opinion formation must be accomplished, at least to some degree, in each individual situation. In fact, political orientation is made up of value, attitude and opinions; but functional political orientation can be further divided into two more elements; "participation demand" and "persistence-support." Searing, Schwartz and Lind (1973:417) then add: "Anyone familiar with the literature will recognize [participation demand and persistence-support] . . . as

the distinction between learning connected with citizen roles and learning connected with subject roles."

Other key concepts in the early socialization process, as evidenced by the survey conducted by Searing and associates, relate to the concepts of "behavior constraints" and the concept of "intervening issue beliefs. They present an example of "behavior constraint" as a situation where there is no longer a general congruence between a person's beliefs and the policies of the political party to which this person has belonged. Nonetheless, the person still places himself or herself on "automatic pilot" in the voting booth and votes the party line (Searing, Schwartz & Lind, 1973:417). In the case of "intervening issue beliefs," it is believed that certain issues affect voting behavior; that is, voting behavior is mediated by specific issue beliefs. It is intervening issue beliefs that cause "switch voting," "cross voting" and "split-ticket voting" patterns (Searing, Schwartz & Lind, 1973:417). It is this ability of the voter to vote along issue lines that most interests social scientists involved in forecasting the future potential of the aging vote.

Searing and associates were not satisfied with the theoretical and research findings in the area of early socialization. Consequently, they developed a generalized political socialization model that allows adult socialization issues to be introduced into the "political socialization equation" They then undertook a research study to validate this theoretical construct.

Searing, Schwartz and Lind (1973:429) substantiated the two following hypotheses in their research study:

1. Much of the adult socialization orientation is generally unrelated to the type of attitudes held toward various political issues of the day.
2. Political party identification does not provide cues for evaluating political action related to political issues.

With the issue of political socialization patterns clearly established on the basis of valid research findings, the next logical issues for investigation would appear to be those of strength and choice of political party attachment among the older adult population.

Issues of Strength and Choice of Political Party Attachments

For many years, older adults were thought to be largely Republican and younger adults were thought to be largely Democrats. A myth has developed in American folklore that, with the passage of time, aging Democrats somehow turn into old Republicans. In fact, Atchley (1980:297) wrote in 1980 that "Among older people, there are about equal proportions of Republicans and Democrats. This finding implies a substantial change with age, since at the younger ages there are many more Democrats than Republicans. . . ." Atchley (1980:297) then adds as a postscript "A closer examination of the longitudinal data suggests that when those who entered politics during and after the New Deal become a majority among older people, a preponderance of Democrats [among older people] may occur."

Consequently, cohort and time or period effects may be important intervening variables in determining the party of choice for a majority of older persons, both at the present time and in the future. Thus, it would appear that Democrat or Republican party membership is largely determined by political socialization processes that have occurred in earlier stages of the life cycle. This phenomenon was fully discussed in the previous section of this study.

Older adults exhibit a strong attachment to their political party of choice; in fact, the strength of this attachment increases for the majority of adults as they grow older. For example, adults in their twenties are only about half as inclined as persons over the age of 65 to identify themselves with a political party in any manner (Atchley, 1980:297).

Issues of the Vote and Other Political Participation

If the older adult is to have a political impact at the national level, then he or she must be politically active. One way this can be accomplished is through the exercise of the right to vote. It has been a long standing "truism" of the literature that the voting activity of persons in the later part of the life cycle declines rapidly with increasing age.

Interest in the relationship between political participation and the human life cycle is not new. Political scientists have investigated this area with increasing interest since the turn of the century. Galtung (1964:164), a noted social scientist, actually used age as an independent variable in his study. It is Gultung's

contention that those under 25 and over 55 do not actually have the available resources to access the political and economic systems in an effective manner. Even here, there is considerable room for argument as not all people over the age of 55 are without the resources to access the political and economic systems. Thus, age as an independent variable, becomes highly suspect in Gultung's research as it does in most other research where this factor is utilized in this manner.

Atchley (1980:295) also starts his investigation of voting participation among the elderly utilizing the voting activities as represented by different cohorts which represented different phases of the life cycle. Voting participation is lowest at age 18 and slowly increases until a plateau is reached somewhere shortly after the respondents reach the age of fifty. This plateau is held until age 65 and then the voting participation curve shows a slow but steady decline. A gender-stratified voting participation curve, according to Atchley, has the same general shape as the unstratified curve except the curve maintains a consistently lower range, indicating a lower voting participation by women of all ages.

In 1968, Glenn and Grimes (1968:563) completed a now "classical study" which clearly established, for the first time, that the decline in voting patterns exhibited by the elderly was not so much related to increasing age as it was to several other intervening variables. For example, the fact that women voted consistently less frequently, on the average, than did men and the fact that there was, of course, a higher rate of women to men in the 65-years-of-age-and-

older category, acted in a manner that reduced the rate of voting for this age group. Also, the educational level was found to be a significant intervening variable. Persons with higher educational levels were more likely to vote and more likely to participate in political affairs in other ways, according to the findings of Glenn and Grimes.

Ley (1980:338), attempting to insure that the full implications of the study by Glenn and Grimes (1968:563-575) were not lost on anyone, states: "However, when these factors of sex and education were controlled by the investigators [Glenn and Grimes], the results were not a drop in voting, but rather a stabilization of participation through ages 50 to 80."

Atchley (1980:297) then evaluates the future implications of the findings of the Glenn and Grimes study when he states: "The importance of this finding [by Glenn and Grimes] is its implication that as the general level of education in our population increases, we should expect the age curve of voter participation to rise faster, peak higher, remain at the high plateau longer, and decline even more slowly than the [present] cross-sectional data indicate."

Age does not, in and of itself, cause anything to happen. It is related, in many cases, to what happens because increasing age signifies passing time and passing time may or may not permit certain things to come to pass. But to place "age" into a cause-and-effect paradigm is a highly questionable undertaking, at best. Atchley (1980:296), for example, states that: "Among men, age made much more

difference in percent voting for those with only elementary or some high school education than for those who graduated from college."

This quotation is an excellent example of the type of semantic trap set for the unwary in the aging literature. Atchley is a highly respected gerontologist, who is abreast of the best thinking and the latest techniques being used in the field of aging theory. Atchley stated above that there are at least two intervening variables between men in his study and their voting patterns. One intervening variable is stated to be that of education; the other is not identified by Atchley himself although the reader might think that it is age. Actually, the strongest candidate for this position is what is called the "cohort effect" in the literature; however, without direct access to Atchley's data base, it would be impossible to state with any certainty what this second intervening variable is.

The myth of the decreasing political activity on the part of the elderly has been further challenged by the most recent work of Verba and Nie (1972:138). In this work, the authors contend that there are powerful intervening variables in operation in relationship to the voting activities, as well as the other political participation patterns of the elderly. Also, it should be noted that Glenn and Grimes (1968:563-579) stratify the elderly population in their study by education and gender while Verba and Nie (1972:8-29) stratify the elderly population in their study according to education and income.

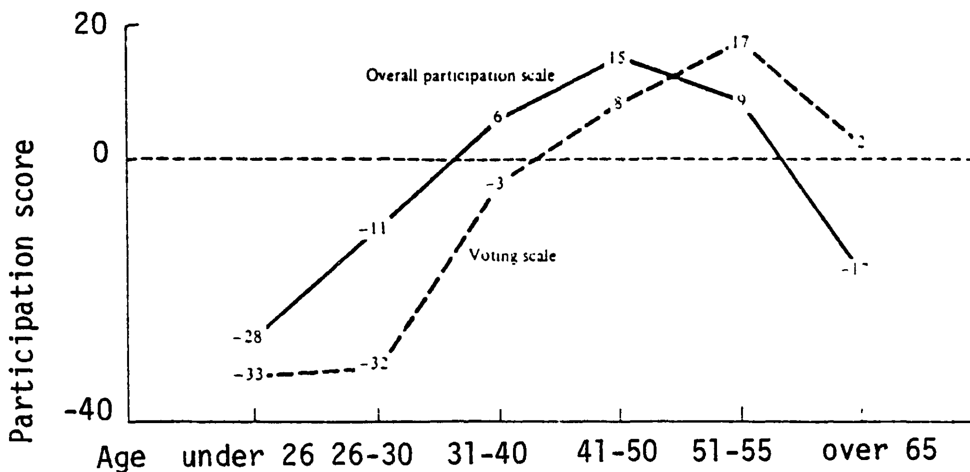
Dowd (1980:23) seems to concur with this technique when he states:

> One solution is to assign to old people the class designations they would have if they were still working at the jobs they held most of their lives. There are sound reasons for doing this. Research on status attainment in old age suggests that status is still largely determined by the same variable that predicted income in mid-life--namely, education.

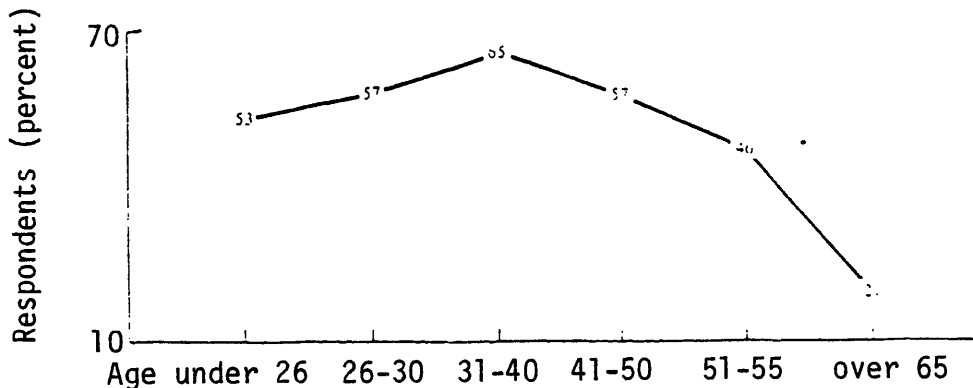
The Verba and Nie study (1972:8-29) reviews briefly the developmental life cycle and its relationship to political activity as reflected by the data obtained in their study (see Figure 13). They reference the young adult, the adult and the older adult in relationship to a range of social responsibilities, including that of political activity. The stratified population samples permit a study of political behavior not only according to age but also according to social class. It is the latter factor, however, that carries the power of explicating political action as a factor related to education and income.

The young adult is concerned primarily with a series of "beginnings"; the adult, with "continuing," the older adult, with "maintaining." These various positions affect the political activities for persons in each of these age groups; but the factors making up the socioeconomic status of each individual in each group also act as powerful mediators in the area of political activities.

In the Verba and Nie study (1972:8), the middle-age adults (the 35-55 age range) are said to have high political activity indices. In fact, the scores of this group, uncorrected for socioeconomic status, are higher for both overall political participation and voting activity than are those scores that have been corrected for socioeconomic factors (see Figure 14).



Life Cycle and Participation: Overall Participation and Voting

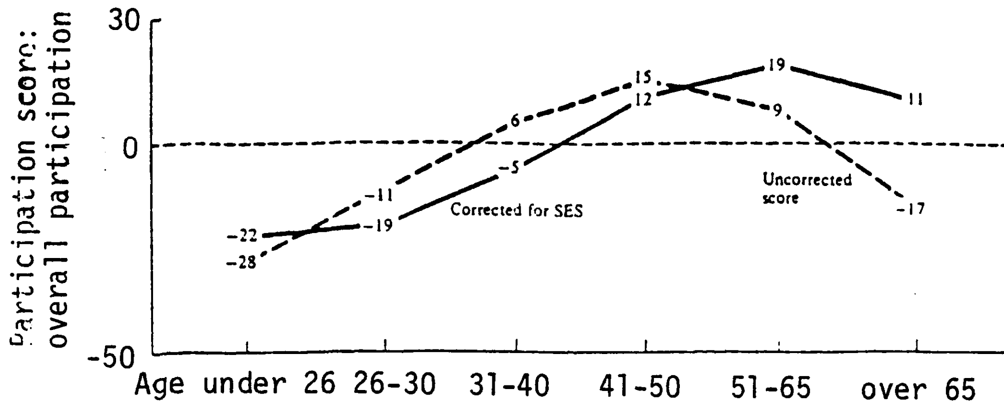


Percentage of Respondents in Upper Half of SES Scale at Different Age Levels

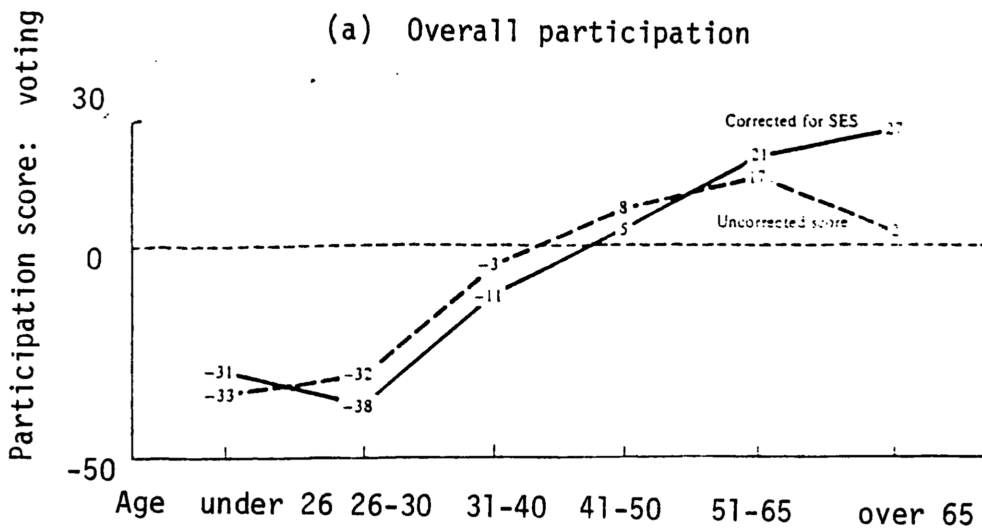
Source: S. Verba and N. H. Nie. Participation in American Political Democracy and Social Equality. New York: Harper and Row, Publishers, 1972, p. 140.

FIGURE 13

LIFE CYCLE AND PARTICIPATION: CORRECTED FOR SOCIOECONOMIC STATUS



(a) Overall participation



(b) voting

Source: S. Verba and N. H. Nie. Participation in America: Political Democracy and Social Equality. New York: Harper and Row, Publishers, 1972, p. 141.

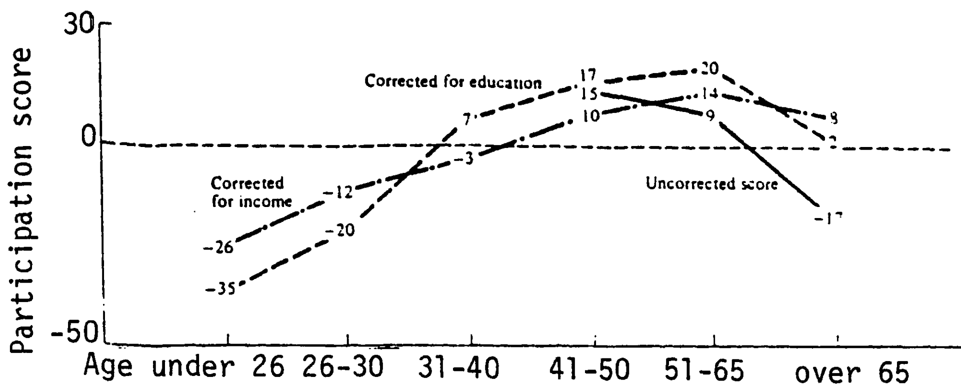
FIGURE 14

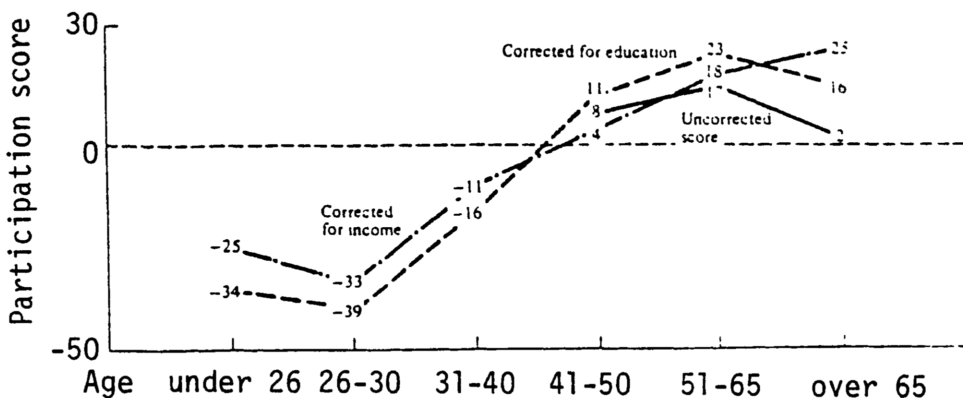
LIFE CYCLE AND PARTICIPATION: CORRECTED FOR SOCIOECONOMIC STATUS

The generally high political activity indices for the middle-age adults are rather easy to explain. At the age of 35, careers have usually been firmly established or are well into the process. Likewise, families have often been started and homes have been purchased, sometimes with very heavy and very long-term mortgages. This group is the "locked in" group. The "situational lock in" for the members of this group frequently encourages new political awareness on the part of these members.

Verba and Nie (1972:144) state that the older adults in their study of the upper socioeconomic range of a population group showed one significant change. For the very first time, overall participation dropped below the voting activities; but, they add that the voting patterns continue to increase rapidly until the age of 65. Overall political participation begins a decline after the age of 50 (see Figure 15).

The juxtaposition of the overall political participation indices for the group corrected for socioeconomic status and for the group where no correction was made shows that participation decreased during the age range of 51-65 for the first group and during the age range of 41-50 for the second group. Meanwhile, the group corrected for socioeconomic status continued to increase in percentage of persons voting, through the age of 65. The data are terminated at this point, so 65 does not imply a downturn, as such, in the voting indices for this group.





Source: S. Verba and N. H. Nie. Participation in America: Political Democracy and Social Edquality. New York: Harper and Row, Publishers, 1972, p. 144.

FIGURE 15

LIFE CYCLE AND PARTICIPATION: CORRECTED FOR EDUCATION AND INCOME SEPARATELY

Older Persons as a Subculture or as a Social Movement

In the early 1960's, the late Arnold M. Rose first introduced the argument of the aging population as a subculture in several journal articles that were later reprinted in his book entitled Older People and Their World (1965).

Rose's theory (1965:4-5) of the "aging as a subculture" is simple and straightforward. It is based on a series of eight propositions:

1. There is a growing number and proportion of persons who live beyond the age of 65.
2. There has been a tendency for a much larger proportion of the population to reach the age of 65 in physical vigor and health.
3. There is a tendency for older people to live to advanced age where chronic illnesses is most likely to be experienced at great expense to those concerned.
4. There have been some recent self-segregating trends among older people.
5. There has been an increase in compulsory and voluntary retirement among the over 65 age group.
6. There are long-run improvements in the standard of living and in the educational level of the over 65 age group.
7. The development of social welfare services for the elderly serves to bring them together and encourages the

elderly to identify with one another and to develop a subculture.

8. There has been less of a tendency recently for adult children to live in the houses of the elderly who continue to act as the head of the household. This separation of vigorous older people from constant contact with adult offspring helps to create the conditions for the development of a subculture.

According to Baum and Baum (1980:93), Pratt is concerned primarily with age-based organizations and the way that they represent the elderly in politics. These organizations, according to Pratt, are all a manifestation of the same social movement, a social movement with a theme stressing "aging" and "the aged," which does not actually help the aging in any way. Also, Baum (1980:93) states: "Pratt believes that all age-based organizations, each in its own way, contribute to the development of increasingly benign public views of aging."

According to Baum and Baum (1980:93) Binstock stresses the competitiveness and the lack of cooperation of the voluntary aging groups presently working for the aging interest in the political arena. The single most easily identifiable goal for each of the aging organizations is, according to Binstock, to be the "loudest voice" in the aging field (Baum & Baum, 1980:93).

A further mention will be made here of Rosow since, as was stated earlier, he represents the most pessimistic of Rose's critics (Baum & Baum, 1980:76). Rosow is a highly respected and

nationally known sociologist. Much of his work has been accomplished in the area of social integration theory.

It has become somewhat of a tradition for aging theorists to take, or to be forced to take, a position on the "Rose Argument" at some point in their writing careers. The literature is full of references to Rose, to Rose's argument and to the implications of Rose's position. Rosow is just one of his many protagonists.

There are, or course, other protagonists in the battle, both "pro" and "con," relating to the "aging as a subculture" argument. For example, Douglas Ley (1980:335-355), a noted student of the aged in national politics, singles out both Henry J. Pratt and Robert Binstock as capable opponents of the "aging as subculture" concept. Pratt (1976:21) stresses that the groups of older persons gathered for purposes of politics should be treated as more of a "bona fide" social movement, or as movements whose primary aims are to obtain increased benefits and equality for the aged. Binstock (1972:265-280), on the other hand, stresses the current involvement of older persons in politics as "just another example" of interest-group liberalism at work on the American scene.

However, the most pessimistic critic of Rose's theory of the "aging as a subculture" is, without a doubt, Rosow. Baum and Baum (1980:78) state:

> In . . . Rosow's opinion, a general devaluation of old age would automatically stop any attempts at age-based politics. Efforts to mobilize the elderly as a separate political force would lead to little more than hostility by the general population. In such a contest between the generations, the elderly as a minority, no matter how sizable, would be the losers.

Rosow (1974:71) states:

> Accordingly, the eventual emergence of group consciousness among the aged is at best extremely problematic. Rose acknowledges that only a minority of older persons now has such an identification [that links them to the elderly group], but he asserts that there is a definite trend in its development. At the same time, he offers no evidence of such a trend. . . . What is at stake here is the conversion of older people from a social category into viable, self-conscious groups. . . .

In summary, Rose does, indeed have his critics. But Rose may be partially right in the long run. The older adults may, over the next 20 years, become a much more viable political force than the present critic are inclined to admit.

The "No-Norm" Theory of Aging

Rosow's (1974) theory of the "no-norm theory" of old age, is developed in his well-known book entitled Socialization in Old Age. In this book, Rosow stresses that social integration of an individual into society can be analyzed in terms of:

1. Social values
2. Social roles
3. Group memberships
    a. Formal organizations
    b. Informal groups.

In reference to social values, Rosow stresses that older people do not differ on basic social values from members of younger cohorts as a result of the function of age per se. The argument here is of some subtlety and worth perusing. The key concepts are "basic social values" and "as a result . . . of age."

The first problem is the definition of "basic social values." Social values can change as was shown in the research by Searing, Schwartz and Lind (1973:415-433). Are these changes considered to be "basic social values"? It appears that the word "basic" could be interpreted as "highly germane"; that is, "highly germane social values" in relation to the topic under discussion; hence "basic social values" are "values highly germane to whatever subject is being considered." If political orientation is the topic, then the "basic social values" are those social values that are "highly germane to the topic of political orientation." These social values can and do change (Searing, Schwartz, & Lind, 1973:415-433); basic social values can and do change over time.

The second problem relates to the change in basic social values as a result of age. No competent researcher in the 1970's or 1980's would even attempt to defend the position that a change, any change for that matter, that occurs in or to an older adult is or was caused by age and age alone. Rosow is simply stating a "truism" of the literature. This "truism" seems to detract the reader from a whole series of other possibilities that might result in change in basic social value, such as situation deprivations that result in status inconsistencies (Trela, 1972:126-147).

Rosow would have been more accurate if he had stated that basic social values are rather impervious to change. These values are frequently learned early and maintained with great tenacity as they serve as building blocks for both personality and the individual's concept of social reality. When, defined in one way, basic social

values can and do change if the conditions are right for such change, regardless of the age of the person involved.

Rosow's (1974:28) "no-norm theory" of old age stresses social values, social roles and group memberships. Rosow's attempts to hold "social values" constant by announcing that these do not change. He permits some variation in group membership to occur, but he declares this element to be rather secondary when compared to the elements of "social value" and "social roles." At this point, he declares that social roles for older people, as such, do not exist. As Rosow sees it, there are no primary social roles for people in the elderly group. Furthermore, there are not likely to be any primary social roles for members of this group because social roles are constructed of social values in the shape of social norms. Consequently, if no new social values are possible, then no new social roles are possible either.

In summary, the Rosow argument is that there are no social roles for older adults at the present time; furthermore, there are not likely to be any social norms for older adults in the future either because:

1. Social roles are constructed of social norms.
2. Social norms are constructed of basic social values.
3. Basic social values do not change; thus social roles cannot change.

Rosow's argument has a great deal of merit. It directs the attention of the reader to the concept of "basic social value" and its position in the construction of social role. The argument may

not convince the reader of the absolute unchangeability of the concept of "basic social value," but it does delineate the problem of appropriate social norms and appropriate social roles for the elderly. And, in addition, it does stress the relative absence of valid social roles for the elderly in American society.

Of course, if social roles do not change, then, according to Rosow, the older adult can never develop a "new" sense of group consciousness that would link him or her to the older adult group. Without group consciousness on the part of the older adult, the argument continues, he or she can never become a politically active segment of a group engaged in aging politics at the national level.

The Status Inconsistency Theory of Aging

Status inconsistency is defined as "the consequences of the holding of several [socially] rank positions, either simultaneously or sequentially, in which these positions, due to the dimensions of stratification, result in diverse valuation by members of society" (Trela, 1972:126). Since it is assumed that each social position reflects a social status in a particular society, then a person holding several social positions, either simultaneously or sequentially, will be the recipient of social rewards connected with each status position. Where the status positions occupied have discrepant stratification ranks, status inconsistency is said to occur. Status inconsistency is based on four theoretical assumptions:

1. The status or rank structure of a group is not a unidimensional phenomenon; it has both vertical and horizontal dimensions.
2. The status of any individual (or group) normally involves the coexistence of a number of imperfectly correlated ranks, on parallel vertical hierarchies.
3. The possession of discrepent ranks in various status hierarchies creates social and psychological strain or stress.
4. The stress generated by the holding of discrepant ranks causes an individual or group to adopt a course of action designed to bring their ranks in line with one another (Trela, 1972:127).

According to Trela (1972:128), inconsistency on the parameters of socioeconomic achievement and ascribed status are the elements most likely to result in an overt political response by the individual involved in status inconsistency. For example, a low racial status and a high occupational status may result in status inconsistency, or the devaluation of the elderly can result in status inconsistency.

Of course, the devaluation of the elderly can have several possible results. First, one becomes old only slowly; however, as age increases, one may perceive that he or she is occupying a social status that is sharply devalued by other members of society. The reaction of the person involved depends on the person's status profile. If the status profile is low--that is, if the social status positions held by the person and which make up the profile have

always been low--then there is no resulting status inconsistency. If, however, the person's status profile is high--that is, if the social status positions held by the person have been high--then the low social valuation of the person as "elderly" may result in a perceived status inconsistency on the part of the person being evaluated.

Trela (1972:131) relates status inconsistency directly to aging politics when he states:

1. A political response to the stress of status inconsistency is highly probable, while other responses are largely precluded.
2. Past political movements of the aged can be partially explained by the status inconsistency framework.
3. The conversion of stress into collective political action by the aged who are suffering from status inconsistency is largely contingent upon the prevailing political conditions and other factors.

In summary, Trela and Rosow share some common ground but then differ on an important issue. Rosow (1974:29) stresses the unchanging nature of basic social value which restricts the generation of new social roles in old age; whereas, Trela (1972:131) stresses that social value can be directly related to social roles and that when these social roles disappear, as many of them do as a person moves from middle to old age, the person's perception of his or her status profile may not change significantly, at least not at first. Where such a situation does develop, the person frequently experiences a

change in basic social values in the political area. He or she suddenly becomes a politically active older person. It is to the political process, in American society, that persons suffering from status inconsistencies frequently turn for relief. Political activities then serve both to lower the anxiety level of the persons suffering from status inconsistencies and, at the same time, to allow the elderly to work for public policies that relate to the older population.

It would appear that Rosow and Trela both agree that basic value beliefs are not given up easily; however, Trela's position is that some alteration in basic value beliefs can occur among older people, especially in the area of political efficacy. From this process, older persons can develop new social roles as political activists.

In summary, the older adult is, on the average, a politically active person, even more so than younger persons, with the single exception of the 45- to 55-year-old cohort. Considering such factors as health and economics, a larger percentage of older adults who are able to vote do so than is true even for the 45- to 55-year-old group.

It was seen that political socialization commences early in life; however, adult experiences can and do make an input into this process. Even in old age, persons frequently reconsider and change their political positions, and they frequently vote along issue lines, provided, of course, they feel that these issues are of great importance to them. It is this potential, plus the fact that the older adults are exceptionally active as voters, that gives

added value to the argument that the older adult has great potential as an effective political actor in the future.

Summary

To investigate the older adult as a political actor of the next 20 years, it was necessary to undertake a rather ambitious research program. The information search necessitated work in the fields of demography, psychology, sociology, economics, the health science and, of course, political science.

In conclusion, it appears that the older adults of the future possess considerable potential as political actors in the future. It is true that there are problems with group consciousness among the elderly; nonetheless, at least in national politics, the future trends seem to indicate a stronger position in the future for members of this group.

CHAPTER III

THE NATIONAL AGING-ORIENTED ORGANIZATION AS POLITICAL ACTOR

This study concentrates on three main "actor groups" which are active in the area of politics which is primarily oriented toward the older adult. The first of these groups is, of course, the older adults themselves; the second is the voluntary aging-oriented organizations; and the third group is that of the national policymakers who are professionals concerned with and active in areas that primarily impact on older adults. This section of the study concentrates on the second of these groups, the aging-oriented organizations. Of course, in the futures forecasts conducted in conjunction with this study, the various decisionmakers in these aging-oriented organizations supply the appropriate information for these aging-oriented organizations.

The reason for selecting aging-oriented organizations as one of the three main "actor groups" has been well expressed by Binstock (1972:268) when he states:

> The . . . general character of American politics suggests that these organizations, in fact, are the most likely sources of political leverages for the aged, whether through effective articulation of interests leading to the development of a cohesive voting block or through modes of organized political activity.

Brief History of Early Age-Related Social Movements

The term "aging-oriented organizations" in this study does not include the early social movements related to aging-oriented politics, which occurred in California in the 1930's and 1940's, simply because these movements were not of national importance.

However, the movements furnish a historical context for the aging-oriented organizations that were to have a national impact on aging-oriented politics in the 1960's and 1970's. Consequently, these early social movements are reviewed here.

The "End Poverty in California" Movement

Aging-oriented social movements began in California in the 1930's. A forerunner of these groups was the "End Poverty in California" movement, called EPIC for short, which was started by the famous writer and social activist, Upton Sinclair. Among the wide range of social programs it sponsored, the EPIC movement advocated a fully articulated old-age pension plan. The EPIC movement had very little political impact in California, however, and when Sinclair ran for and lost the state governorship in the early 1930's, EPIC died with his political aspirations (Pinner, Jacobs & Selznick, 1959:3-4).

The Townsend Movement

The first of the "bona fide" aging-oriented social movements was the "Old Age Revolving Pensions, Incorporated." This movement originated by Dr. Francis E. Townsend, came into being in the early 1930's just as the EPIC program was beginning to decline. Originally, the "Townsend Plan," as it was called, sponsored a monthly pension of $200 for every U. S. Citizen 60 years of age or older. Townsend stressed that the plan was a way to increase citizen purchasing power, thereby stimulating both business activity and production and employment

pursuits at a time when these were badly needed by the national economy (Pinner, Jacobs & Selznick, 1959:4).

After experiencing various vicissitudes, the Townsend movement was able, after a long struggle, to get one initiative on the ballot calling for a 60-dollar monthly pension for older people. With the defeat in 1944 of this one supreme political act, the Townsend movement expired as an effective political force (Pinner, Jacobs & Selznick, 1959:4).

The "Ham and Eggs" Movement

The next aging-oriented group was the Ham and Eggs movement. The group had several official names over a period of time from 1935 through 1950. For example, it was called the California Pension Plan (1936), the California Life Retirement Payments Association (1938), the Payroll Guarantee Association (1942), the California Bill of Rights Association (1948), and the Pension and Taxpayers, Incorporated (1950) (Pinner, Jacobs & Selznick, 1959:4).

In 1938 this movement came under the control of the unsavory Allen brothers, Willis and Lawrence. Politically, this group was a little more successful than its predecessor, the Pension and Taxpayers, Incorporated. Over the thirteen years following takeover by the Allen brothers, this group was able to place four initiatives on the ballot, all of which were defeated, however,

The McClain Movement

In the early 1940's, George McClain created a "Citizens Committee for Old Age Pensions," currently called the "California Institute of Social Welfare" (CISW). McClain holds the distinction of being the first real organizer, in a political sense, of the elderly in both California and in the United States.

Pratt (1976:34) states:

> . . . McClain knew how to build a pressure-group structure and to turn it forcefully toward the achievement of policy goals. The fact that the state old age pension expenditures in California soared from $68 million in fiscal 1940-41 to $223 million in 1950-51 and to $375 million in 1968-69 has been attributed in at least two scholarly studies to the effectiveness of the state old-age lobby, of which McClain's organization was the leading component.

The odd thing about the entire McClain movement is that everyone, even the organizational insiders, seemed to think that the general issue of the old-age pension was at the core of the McClain movement. This idea has been reinforced in the minds of the most concerned viewers because the topic of pensions has been a favorite subject for McClain and his executives at meetings and on various radio and television programs. No action has ever been formally initiated in this area by McClain's organization, however (Pinner, Jacobs & Selznick, 1959:21).

Although the CISW is still active in California, the effectiveness of this aging-oriented group has been seriously curtailed since the 1960's. In addition, the CISW has never had much effect at the national level despite the fact that McClain did try to integrate

the movement into national politics over a period of several years (Pinner, Jacobs & Selznick, 1959:257-264).

The study by Pinner, Jacobs and Selznick (1959:265-271) makes the following summary statements:

1. The CISW was organized by a political entrepreneur who has exercised exclusive personal control over the organization and yet this exclusive control has afforded the leader but limited opportunities to use organizational resources for his personal political advancement.
2. The CISW is not an integrated part of the community; hence its actions tend to be lacking in responsibility and effectiveness.
3. The old-age assistance recipients that Pinner and associates studied showed evidence of status anxiety.
4. California's old-age security laws permit some pensioners to enjoy a "slightly privileged status," and this group supplies a disproportionate share of the CISW membership.
5. Membership in the CISW does not offer new and satisfying personal ties.
6. Participation in the CISW leads members to focus pre-existing negative feelings under specific targets and increases their isolation from the community.
7. Communication within the organization runs from the energizing leader to the receptive, passive audience; but the members in turn communicate their dependency,

admiration and guilt to one another and back to the leader.

8. There are wide variations in the degree of involvement of McClain's followers; and the organization is sustained by a fluctuating core of devoted, self-sacrificing members.
9. McClain has been able to mobilize the strength of his organization and place his initiative measures on the ballot, but his ability to influence the voting public is low.
10. The McClain organization is basically unstable and is dependent on continuous exhortation by an indispensable leader.
11. The McClain program does not involve basic opposition to the existing social and legal order but strives for smaller incremental changes within the existing system.

Brief History of Contemporary Aging-Oriented Organizations

To qualify as a national aging-oriented organization in the research study, an organization must maintain active involvement in the area of aging-oriented politics at the national level on a year-round basis. According to Pratt (1976:87), there are only ten organizations that qualify as national aging-oriented organizations under these terms. Pratt divides these ten organizations into several categories: the mass membership organizations, the trade

associations, the professional societies, the confederations and the ethnic groups.

The voluntary aging organizations in each of these 10 main categories are:

1. The National Retired Teachers Association (NRTA)--a mass membership organization that lists its membership jointly with its sister organization, the American Association of Retired Persons (AARP), at between 3,000,000 and 15,000,000 members, depending on the source of information used.
2. The American Association of Retired Persons (AARP)--a mass membership organization that lists its membership jointly with its sister organization, the National Retired Teachers Association (see membership figures cited above for the NRTA-AARP organizations.)
3. The National Council of Senior Citizens (NCSC)--a mass membership organization with approximately 3 million members.
4. The National Council on the Aging (NCOA)--a mass membership organization of social workers using a confederated organizational structure and working in association with other groups of similar interests claiming approximately 1,900 members, many of which are organizations.

5. The National Association of Retired Federal Employees (NARFE)--a mass membership group with approximately 150,000 members.
6. The American Association of Homes for the Aging (AAHA) --a trade association with approximately 1,000 members.
7. The American Nursing Home Association (NAHA)--a trade association with less than 500 members.
8. The National Council of Health Care Services (HCHCS) --a trade association with less than 500 members.
9. The National Association of State Units (NASU)--a trade association with less than 500 members.
10. The National Caucus on the Black Aged (NCBA)--a ethnic-oriented group with less than 500 members.

For the purposes of this research study, there are mass membership and non-mass membership organizations. The mass membership organizations are of primary interest in this study. These are the National Retired Teachers Association (NRTA), the American Association of Retired Persons (AARP), the National Council of Senior Citizens (NCSC), the National Council on the Aging (NCOA) and the National Association of Retired Federal Employees (NARFE). The non-mass membership groups include a group of trade associations and a small ethnic-oriented group. Most of these groups are extremely powerful bodies. However, they have specialized goals and objectives that do relate easily to the general welfare of the majority of older adults.

The Retired Teachers Association

According to the handbook of the National Retired Teachers Association (NRTA) published as guidance for the NRTA local units throughout the country, NRTA was founded on October 13, 1947, as a national voluntary membership organization for retired teachers. The organization was founded under the leadership of Dr. Ethel Percy Andrus, a retired Los Angeles high school principal (National Retired, 1980:2).

Originally, the NRTA was founded to work on behalf of retired teachers in the area of pension reforms and various other benefits. Dr. Andrus was particularly interested in obtaining life insurance for NRTA members. This proved to be a most difficult task for her as insurance companies did not consider the underwriting of insurance for a group of elderly retirees to be a particularly attractive profit-making venture. Finally, with the help of Leonard Davis, a person over forty years her junior, Dr. Andrus convinced the Continental Casualty Company to underwrite life insurance policies for NRTA members.

The plan was an immediate and overwhelming success. In fact, persons who had not had careers as teachers asked to be permitted to join the insurance part of the NRTA program. Rather than turn these persons away and rather than change the original charter regarding membership requirements, Dr. Andrus and Mr. Davis founded a new aging-oriented organization for nonteachers in 1958. By design, members of this group then qualified for the same life insurance

program as did members of NRTA. This venture was also a grand success. In fact, Pratt (1976:90) states:

> . . . as his part of the bargain, Davis agreed to invest 50,000 dollars of his own capital, an investment, incidently, which has paid off handsomely for him: the value of his NRTA-AARP related insurance holdings in a recent year (1972) was estimated at 184,000,000 dollars [and these holdings have since more than doubled].

Regarding NRTA's membership, the national organization states:

> Today, NRTA is the professional association of more than 500,000 retired and former teachers and administrators. Its programs serve the social and economic interests of its own members and [also those of] the members of its sister organization, the American Association of Retired Persons (AARP) (National Retired, 1980:2).

The philosophy of the NRTA is to assist NRTA members to enjoy retirement and maintain their purpose, independence and dignity through activity, usefulness and service to others. Their motto is "to serve, not to be served" (National Retired, 1980:2).

The goals of the NRTA are:

1. To foster and promote the social welfare, educational, scientific and philanthropic objectives and needs of retired teachers, administrators and all other persons who are either members of the Association or eligible for membership.
2. To work in cooperation with other national, state and local educational, retiree and other organizations to improve the quality of life for retired teachers, school administrators and all older people of America so that aging is achieved with independence, dignity and purpose.

3. To sponsor research on physical, psychological, social, economic, and other aspects of aging for the benefit of all older persons, both now and in the future (National Retired, 1980:2).

The members of the NRTA Board of Directors and all the national officers are elected by delegates attending the NRTA National Convention held in even-numbered years.

The NRTA Board of Directors is the Association's major policy and decision making body. This Board consists of 3 different classes of directors, each class being composed of 5 members with a new class of 5 members elected at each national biennial convention to serve for a period of 6 years. With the new class of 5 members present, the board then elects a chairman and a vice-chairman for two years each.

The national officers of the NRTA are the president, vice-president, the secretary and the treasurer. The vice-president serves in an every-changing role--the first two years he serves as the vice-president. The next two years he serves as the president-elect. The last two years he serves as the president.

The president presides at all national meetings and conferences sponsored by the NRTA, makes official appointments, and serves as ex-officio member of all National Advisory Committees, with the exceptions of the Nominating and Resolutions Committees.

The Executive Committee is responsible directly to the Board of Directors. The Executive Committee meets five times each year in joint session with the Executive Committee of the AARP. This committee is composed of the president, the president-elect, the

board chairman, the board vice-chairman, and the immediate past president of the NRTA.

The National Advisory Committees consider and make recommendations on a wide series of issues affecting both the NRTA and the older Americans as a group. There are three, not the usual one, Public Affairs National Advisory Committees, which are of particular importance in the aging politics and public policy area.

The NRTA has nine administrative areas established on a geographical basis under the direction of nine area representatives, each of whom heads an area team. The area team deals with day-to-day problems and serves as a conduit for the national office in providing services, programs and support to the local level.

At the local level, six major committees and two workshops are stressed: the legislative committee, the membership committee, the nominating committee, the program committee, the public affairs committee, the public relations committee, the legislative workshops, and the special workshops.

The committee missions are stated in their titles. The workshops, however, deserve a fuller explanation. The legislative workshops are the key to political involvement for the older adult. These workshops are planned by the state volunteer officers, referred to as the "Retired Teachers Association State Volunteer Officers." At these workshops, unit leaders at the local levels are assisted in developing a series of sophisticated skills that will help them in educating both the members of the general public and members of the legislature about issues concerning older adults.

These workshops are different from the workshops planned by the Retired Teachers Association Legislative Committee, which help state-level personnel develop a series of highly effective techniques that are to be used when working with state- and national-level legislators. These special workshops provide a highly informative series of sessions between the NRTA volunteer officers and the various local unit leaders.

The NRTA is not all boards of governors, national officers, advisory committees, and specialized state and local committees. If it were, it is doubtful that the NRTA would have the appeal for the masses that has resulted in such a large membership enrollment. Of course, the NRTA is many different things, at many different levels, to many different people. For example, at the national level, the NRTA provides:

1. Publications, including the colorful bimonthly magazine the NRTA Journal and the monthly NRTA News Bulletin
2. Legislative representation at the national and state levels
3. Interesting programs
4. Leadership training sessions
5. Issue Forums on topics of major concern
6. Conventions and conferences on special topics
7. Eligibility for group health insurance
8. Membership in motoring clubs

9. An outstanding Pharmacy Service offering prescription medicines and other health needs by mail-order and direct service pharmacy service in eight major cities
10. Money Market Fund operations
11. Discounts for purchases from major hotel and motel chains and from auto rental agencies nationwide through the "NRTA Purchase Privilege Program."

At the state level, the NRTA or its state representative is the supplier of services related to:

1. Legislative representation
2. Program assistance
3. News Bulletin
4. Conferences
5. Conventions

At the local level, the NRTA or its local representative is the supplier of services related to:

1. Fellowship with retired colleagues
2. Informative and protective services
3. Legislative representation
4. Community participation activities
5. Pre-retirement program activities.

The representatives of the NRTA, using highly effective and well-organized methods, contact potential members using a great variety of communication channels which have been individually assessed for their marketing potential in relationship to the target population. Organization and effective planning are

stressed. Older members learn, many for the very first time, how to organize and how to operate in a dynamic situation.

Pratt (1976:90) states:

> In view of its auspicious beginnings, it is scarcely surprising that combined dues-paying membership of NRTA-AARP easily makes it the largest organization of its kind in the country. It grew in size from a modest 150,000 in 1959 to about 1 million in 1969, to 6.2 million in late 1973, and to more than 9 million in 1975, making it one of the largest voluntary bodies in the country.

The Association of Retired Persons

As was stated earlier, on October 13, 1947, the NRTA was founded. Then the same people who founded NRTA also founded AARP on April 30, 1958. These programs are best called "shared programs" for the two organizations are legally two separate corporations; however, the two programs share many things--the same philosophy, the same overall goals, the same president and many of the same services and most of the same programs.

Moreover, the NRTA-AAPR share joint Executive Committee sessions, Joint Legislative Committee sessions, joint NRTA-AARP National Legislative Committee sessions, and joint National Advisory Committee sessions. They also work together at the Area Leadership meetings and cooperate in a variety of projects, programs and services at the local level. In fact, in local areas where both organizations are active, joint efforts in all areas are strongly encouraged.

At the state level, which is administratively just below the joint NRTA-AARP Area Office, the NRTA has a State Director who serves as the central administrative liaison between the AARP and the NRTA members for both state and local units.

The NRTA-AARP area offices, the regional component of the administrative network, is headed by an Area Representative. The Area Representative has an Assistant Area Representative assigned to the functions of liaison support for NRTA-AARP and for support of both NRTA area volunteer officers and state RTA officers (the state level officers drop the word "National" from their designation thereby becoming RTA's instead of NRTA's). The staff also provides a wide range of highly sophisticated, technical services in developing, initiating, and administering meetings, seminars, workshops, conferences and committees.

The NRTA-AARP National Legislative Committee sessions act as a model for the various Joint State Legislative Committee sessions. The AARP Chapter Legislative Committee Guide (American Association, 1980:21) states:

> The legislative program is implemented in each state through a Joint NRTA/AARP State Legislative Committee. Sometime before the state legislature convenes, the Committee in each state selects its own legislative objectives from among the state legislative guidelines and works to achieve these goals during the next session of the State Legislature. Each of these Committees is an operating entity composed of representative members (5 or 6) from each Association, recommended by the State Director with the approval of the Area Vice President.

At the close of the legislative session, an analysis is made of the various accomplishments of the AARP unit, by the AARP unit working in conjunction with the national office. These analyses

are published and widely distributed throughout the United States. Each local chapter, using these reports, then recommends several objectives to be accomplished in the next state legislative session (American Association, 1980:24). In this manner, the local units are tied into the state-level program and the state-level programs are tied into the national-level program using exactly the same administrative format.

The AARP Chapter Legislative Committee Guide (American Association, 1980:11) states its nonpartisan policy in this manner:

> An AARP chapter should never officially support a candidate for public office. Although individual members are encouraged to vote and support any candidate they desire, they should be careful not to confuse their personal preference with a formal chapter endorsement. It is appropriate for the president of an AARP chapter to refrain from any public endorsement since his position might be interpreted as an Association stance.
>
> This non-partisan policy also holds true with regard to political parties. Individual members should work for the party of their choice, but it must remain clear that AARP is made up of members of all parties and as such does not endorse any partisan group.
>
> AARP and each AARP chapter support and oppose issues, rather than parties or candidates. When a chapter does not take a stand on an issue and particular members feel strongly about it, they are free to work as individuals.

The nonpartisan stance of AARP, applies with equal force to NRTA members as well. There are, however, ways for an organization to be politically effective other than their having to give formal endorsement to particular political parties or to specific political candidates.

The National Council of Senior Citizens

The National Council of Senior Citizens grew out of the 1960 Senior Citizens for Kennedy effort. With political sentiment growing in favor of the passage of a health assistance program for older persons, later to be called Medicare, and with the strong encouragement of a vocal support group created by the 1961 White House Conference on Aging, a founding convention was held in Detroit in 1961 expressly to organize the NCSC. The United Auto Workers Union and several other industrial unions were preeminently represented. The other full partner in this early venture to organize the elderly into an effective political group on a national basis was the Democratic National Committee. In fact, the Democratic National Committee worked hard to smooth the transitional process that merged the group called the Senior Citizens for Kennedy into the new group called the NCSC. The members of the NCSC have continued to show a strong affection for both the Democratic Party and for several of the larger unions, the United Auto Workers Union in particular.

Pratt (1976:89) states:

> From a small, highly specialized organization whose early efforts were focused largely on a single legislative issue [Medicare], the NCSC grew both in membership and political leverage following the decision in 1965 to expand its range of political goals. There are currently over 3,000 affiliated senior-citizen clubs throughout the country, with a combined membership of over 3 million. The national office estimates that the local clubs are distributed about equally into three categories: trade union retiree groups, religious and ethnic groups, and social welfare retirees.

The National Council on the Aging

NCOA was founded in 1950 under the name of the National Conference on the Aging. It was the first of the five voluntary aging-oriented organizations included in the present study to be "deeply affected by the modern senior movement" (Pratt, 1976:92). In the wave of enthusiasm generated for the elderly by the then upcoming 1951 National Conference on Aging, the National Social Workers of America established a committee to look into the issue of the aging for the impending White House Conference. The committee was called the "National Conference on Aging." After the White House Conference, the committee continued to exist in a feeble manner for the first few years; however, it had gained enough strength by 1960 to become a rather viable organization. Along the way, the name of the organization was changed from the "National Conference on Aging" to the "National Council on Aging."

The expressed purpose of NCOA is to serve as a resource at the national level for planning, information dissemination, consultation, and communications pertaining to older adults. The NCOA Board of Directors is composed of 65 persons from 23 states and the District of Columbia. The board is drawn from the fields of education, medicine, gerontology, labor, industry, religion, government, and of course, various social action agencies (National Council, 1976:4).

The largest share of NCOA funding is presently derived from government contracts; however, NCOA hopes to obtain a larger share of funding during the remaining years of the 1980's and all of the

1990's from foundations, labor unions, private corporations, and in particular, from the United Way. Only the future will tell, of course, how successfully these plans will be implemented.

NCOA has a wide range of interests. It is tied closely to the Senior Center movement, being one of the prime participating organizations at the annual National Conference of Senior Centers. The NCOA was also instrumental in establishing the National Institute of Senior Centers (NISC) In 1970. The NISC offers expert technical assistance for the effective planning and programming of senior centers throughout the nation. These senior centers, however, are not included in any political network established or coordinated by the NCOA. Under the right conditions, these organizations could offer a great deal of potential political power. NISC research reveals that 26 percent of Americans over 55, or some 5 million persons, attend these centers and that an equal number would like to attend but there are no such centers available or accessible to them (National Council, 1976:5).

Another specialized function maintained by NCOA is the Center for Public Policy. This organization unit:

> . . . keeps abreast of all pending legislation and policy decisions affecting the elderly. It maintains a current record and file of pending legislation and public policy issues. It monitors legislation, presents testimony and disseminates information on the elderly to Congress, the Administration, and the public. The Center also assists the Board of Directors in the development of public policy decisions and informs the membership of current legislative and administrative activities that affect the aging and the agencies which serve them. (National Council, 1976:5)

Also, the NCOA Center for Public Policy works closely with the larger organization. For example, under a Schrimper Foundation grant, the impact of Title XX of the Social Security Services Amendment Act on the elderly is being evaluated in relationship to a recommended formal policy position. Also, under a Florence V. Burden Foundation grant the impact of the Employment Retirement Income Security Act of 1974 (pension reform law), and its effects on the older worker, is being evaluated in relationship to a recommended formal policy position (National Council, 1976:7). Consequently, NCOA tends to take political positions on issues related to the elderly only after these issues have been carefully studied and the results have been fully documented by the NCOA Center for Public Policy.

The National Association of Retired Federal Employees

The NARFE is the oldest of the five aging-oriented organizations under discussion here. It was founded in February, 1921, around the time the interest in the passage of the Federal Employees Pension Act was at its highest (Pratt, 1976:91).

The philosophy of the NARFE is to insure the continued dignity of federal employees in their days of retirement and to protect and augment their federal benefits. The NARFE's philosophical position guarantees that it will remain relatively small. Pratt (1976:92) states:

> In recent years, NARFE income, if one discounts the factor of inflation, has grown comparatively little, increasing from $259,000 in 1956 to $329,000 in 1960 and $543,000 in 1971. In 1969 and 1970 the group ran a net operating deficit. During a period of unprecedented membership growth in the . . . two mass-membership groups [NCSC and NARTA-AARP], NARFE's rolls have increased only modestly--a 15 percent increase from 1968 to 1971 and a further 17 percent growth--to 182,000--in 1974.

Federal government employees, in particular, often feel that they represent a unique combination of occupational factors in the labor market. Federal government retirees frequently retain, at least to some degree, this feeling of "uniqueness" among workers in general. This explains how the NARFE could survive even in the face of great competition from the other mass membership aging-oriented organizations mentioned earlier. The unique values, attitudes and beliefs of retired Federal government employees, coupled with a series of special needs, guarantees the continued existence of this organization.

In the past the NARFE has proved itself to be a highly effective political agent. For example, the NARFE had an important part in the passage of both the 1959 Federal Employees Health Benefits Law and the 1972 Amendments to Social Security that guaranteed the cost-of-living increase for recipients of that program. The NARFE would probably continue to exist if it had but one official function--to guard against the "wholesale inclusion" of government employees in the Social Security system. It maintains a highly effective and very powerful lobby to insure that government employees are fully alert to all maneuvers related to their inclusion in the Social Security system. It should be noted here that

the 15-member National Commission on Social Security Reform voted 12-3 in early 1983 to include federal employees with less than five years' service in the Social Security program beginning January 1, 1984. Such a recommendation must be approved by the U. S. Congress; however, the probability is high that this recommendation will be approved at some point within the next three years.

Summary

In summary, three main actor groups were identified as important in the area of aging politics. The first actor group was composed of the older adults. The second actor group was composed of five of the ten aging-oriented organizations that the eminent Professor Henry J. Pratt selected as the main groups "both engaged in politics at the national level and [which are] more or less exclusively preoccupied with old-age problems" (Pratt, 1976:87). These groups had been reviewed in this section in some detail.

CHAPTER IV

NATIONAL POLICYMAKERS AND THE OLDER ADULT

To reiterate, there are three main "actor groups" involved in aging-oriented politics at the national level. These are the older adults, the aging-oriented organizations, and a select group of national policymakers. This section of the research study deals with the last of these groups, the national policymakers. The goal, then, of this section is to identify the various subgroups identified as the national aging policymakers.

Top-level national policymakers involved in formulating aging-oriented public policy are found throughout the various administrative and legislative networks at the federal level. Nonetheless, there are two federal entities that perhaps above all others affect aging-oriented policy in the United States. These two federal bodies are the U. S. Congress and the U. S. Government's Administration on Aging.

The United States Congress

The two legislative bodies of the U. S. Congress, the Senate and House of Representatives, are composed of numerous committees and subcommittees. The members of these committees and subcommittees are frequently supported by a range of highly specialized staff members. Many of these personnel formulate or assist in the formulation of aging policy at the national level.

The United States Senate

Many of the committees and subcommittees of the United States Senate are responsible for formulating policy positions on issues relating to the older adults in the nation. These committees and subcommittees in the U. S. Senate are:

1. The Special Committee on Aging (Program Areas: overseeing and investigative responsibilities on all matters relating to the elderly)
2. Committee on Agriculture, Nutrition and Forestry. The Subcommittee on Nutrition (Program Areas: food stamp and certain other nutrition-related programs)
3. The Committee on Banking, Housing, and Urban Affairs. The Subcommittee of Housing and Urban Affairs (Program Areas: housing programs which serve the elderly; nursing home and intermediate care facilities authorized under the National Housing Act of 1959, Section 232; services to the elderly under Urban Mass Transportation Act)
4. Committee on Finance (Program Areas: Old Age, Survivors, and Disability Insurance Program [Social Security]; Grants to states for medical assistance [Medicaid]; Health Insurance for the aged and disabled [Medicare]; Private Pension Plans; Social Security for low-income individuals authorized under Title XX

of the Social Security Act; Supplemental Security Income [SSI]; Taxation)

A. The Subcommittee on Health (Program Areas: health care programs)

B. The Subcommittee on Private Pension Plans (Program Area: private pension programs)

C. The Subcommittee on Social Security financing (Program Area: Old Age, Survivors and Disability Insurance [Social Security]

D. The Subcommittee on Supplemental Security Income (Program Areas: Supplemental Security Income [SSI])

5. The Committee on Human Resources

A. The Subcommittee on Aging (Program Areas: programs under the Older Americans Act)

B. The Subcommittee on Health and Scientific Research (Program Areas: health care programs)

C. The Subcommittee on Employment, Poverty and Migratory Labor (Program Areas: Senior Opportunities and Services administered by the Communities Services Administration; Older Americans Volunteer Programs administered by ACTION)

D. The Subcommittees of Labor (Program Areas: Private Pension Plans, Railroad Retirement Act, Manpower Program, Age Discrimination in Employment)

E. The Subcommittee on Education, Arts and the Humanities (Program Area: education programs)

6. The Committee on Governmental Affairs

   The Subcommittee of Civil Service and General Services (Program Areas: Civil Service Retirement Act)

7. The Committee on Judiciary

   The Subcommittee on Criminal Laws and Procedures (Program Areas: Law Enforcement Assistance Administration [crime prevention])

8. The Committee on Veteran Affairs

   A. The Subcommittee on Compensation and Pensions (Program Areas: Veterans Pension Program)

   B. The Subcommittee on Health and Readjustment (Program Areas: Health Care Programs)

<u>The United States House of Representatives</u>

The United States House of Representatives also contains a number of committees and subcommittees. Many of these committees and subcommittees are responsible for formulating policy positions on issues relating to the older adults in the nation. These committees and subcommittees in the U. S. House of Representatives are:

1. The Select Committee on Aging

   A. The Subcommittee on Retirement Income and Employment (Program Area: income maintenance and employment)

   B. The Subcommittee on Health and Long-term Care (Program Area: the Health Care Program)

C. The Subcommittee on Housing and Consumer Interests (Program Area: Housing and Consumer Interests)

D. The Subcommittee on Human Services (Program Area: social services for the elderly)

2. The Committee on Agriculture

The Subcommittee on Domestic Marketing, Consumer Relations and Nutrition (Program Areas: Food Stamp Program and certain other nutrition-related programs)

3. The Committee on Banking, Finance and Urban Affairs

The Subcommittee on Housing and Community Development (Program Area: housing programs which serve the elderly)

4. The Committee on Education and Labor (Program Areas: Education Programs, Programs under the Older American Act; Employment programs for the elderly administered by the U. S. Department of Labor; Older American Volunteer programs administered by Action; Age Discrimination in Employment; senior opportunities and services administered by the Community Services Administration; private pension plans)

A. The Subcommittee on Select Education

B. The Subcommittee on Economic Opportunity

C. The Subcommittee on Employment Opportunities

D. The Subcommittee on Manpower, Compensation and Health Safety

E. The Subcommittee on Elementary, Secondary and Vocational Education

5. The Committee on the Judiciary

   The Subcommittee on Crime (Program Area: Law Enforcement Assistance Administration [Crime Prevention])

6. The Committee on Interstate and Foreign Commerce

   A. The Subcommittee on Health and Environment (Program Area: Grants to States for medical assistance programs [Medicaid])

   B. The Subcommittee on Transportation and Commerce (Program Area: Railroad Retirement Act)

7. The Committee on Post Office and Civil Service

   The Subcommittee on Compensation and Employee Benefits (Program Area: Civil Service Retirement Act)

8. The Committee on Public Works and Transportation

   The Subcommittee on Surface Transportation (Program Area: services for the elderly authorized under the Urban Mass Transportation Act)

9. The Committee on Veterans Affairs

   A. The Subcommittee on Compensation, Pension, and Insurance (Program Area: veterans' pension programs)

   B. The Subcommittee on Medical Facilities and Benefits (Program Area: health care program)

10. The Committee on Ways and Means (Program Area: full committee has jurisdiction over taxation and private pension plans.)

A. The Subcommittee on Social Security (Program Area: Old-age, Survivors, and Disability Insurance Pro-ram [Social Security])

B. The Subcommittee on Health (Program Area: health insurance for the aged and disabled [Medicare])

C. The Subcommittee on Public Assistance (Program Area: Supplemental Security Insurance [SSI], social services for low income individuals authorized under Title XX of the Social Security Act).

The Administration on Aging

The Older Americans Act of 1965 created the Administration on Aging (AoA). Title III of this Act authorizes AoA to both encourage and assist state and local agencies in the development of comprehensive and coordinated delivery systems. These delivery systems are to:

1. Help older persons secure and maintain maximum independence and dignity in a home environment,
2. Remove barriers to independence for older persons, and
3. Provide a continuum of care for the vulnerable elderly (Guide to AoA Programs, 1980:2).

The Goal and Objectives of AoA

The formal stated goal of AoA is to help "older people live autonomous, useful, constructive lives for as long as possible in their own homes and communities" (Guide to AoA Programs, 1980:1). To accomplish this goal, AoA strives to bring together, from a wide variety of

sources, ideas and actions concerned with older adults and their needs.

The 1978 amendments to the Older American Act placed a new emphasis on the four following objectives:

1. Helping the states develop systems of community-based services for older persons.
2. Stressing developmental social experiments which bring research, training and demonstration resources to bear on specific social problems.
3. Stressing AoA's interdepartmental role endeavoring to change the behavior of other Federal agencies that have responsibility to serve older adults.
4. Stressing AoA's strong advocacy role for older adults within the Federal government (Guide to AoA Programs, 1980:1).

The Organizational Network of AoA.

There are 10 Regional Offices maintained by the AoA in the United States. There are 57 state agencies (one in each of the 50 states plus one in the District of Columbia, Puerto Rico, the Virgin Islands, Guam, Samoa, the Northern Marianas, and the Trust Territory of the Pacific Islands). In addition, there are nearly 600 area agencies and well over one thousand nutrition projects, some with multiple sites. It should be noted here that the area agencies work with both private and public providers to insure adequate service for older adults (Guide to AoA Programs, 1980:2).

Developmental Social Experiments

The emphasis on developmental social experiments has taken many forms since AoA was created. In the early 1970's the nutrition programs were implemented and proved to be highly successful in meeting the needs of many of the elderly in the area of nutrition as well as in the area of socialization. In the early 1980's, one of the developmental social experiments receiving added emphasis is the long-term-care area as it relates to older adults. Many innovations are being implemented and closely monitored in this service area (Guide to AoA Programs, 1980:3).

Interdepartmental Coordination

AoA's interagency role, at the federal level, operates on the basis of 33 written and signed agreements between AoA and other federal agencies. In this manner considerable coordination in efforts are achieved among these agencies. Also, AoA is authorized to invest funds in joint projects with these various agencies to accomplish the aims of the various agreements (Guide to AoA Programs, 1980:3).

Grant Programs of Special Interest

According to the Guide to AoA Programs (1980:6), the AoA has access to discretionary funds for supporting both pilot and service programs in the following areas:

1. Services to the vulnerable elderly

2. Services to prevent physical and mental deterioration and foster self-sufficiency
3. Promotion of effective advocacy
4. Improvement of management.

Research and Demonstration Projects

The Research, Demonstration and Evaluation programs of AoA develop knowledge and generate information which can be used in aging policy, planning and practice. Activities supported include systematic statistical studies, development projects which convert knowledge or information into usable tools and instruments, field testing of innovative ideas, and promotion of proven models. The Research program supports projects which contribute to the well-being of the elderly by:

1. Identifying and studying current patterns and factors that affect the lives of older persons,
2. Developing, demonstrating and evaluating approaches and methods for improving the life circumstances of older persons, and
3. Developing and disseminating useful materials for utilization by older people, service providers and policy makers (Guide to AoA Programs, 1980:6-7).

It should also be noted that the program gives particular attention to the needs of the very old and to impaired persons. Within these groups the elderly whose problems are aggravated by social isolation, low income, rural residence and minority status

are given special consideration.

In summary, eleven million persons received social services which were supported by the aging network in fiscal 1979. Information and Referral Services were provided for about 2.8 million persons. About 2.2 million persons received transportation services and 1.6 received outreach services. Other services by order of volume delivered were: home social and health services, legal and related counseling, escort services, and home repair and renovation (Guide to AoA Programs, 1980:3).

Summary

At the national level, there are two federal bodies that stand out from all the others in relationship to their importance in formulating national policy relating to older persons in the nation. These two organizations, the U. S. Congress and the U. S. Government's Administration on Aging, have been reviewed in some detail in this section. It is from these two groups that the twenty aging-oriented policymakers were selected who participated in this Delphi study.