GERIATRIC HEALTH AND WELFARE RESOURCES IN THE UNITED STATES TODAY

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with contributions from

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Key words :

The older adult population is changing rapidly, especially in industrialized countries. This puts a high priority on public policy, societal resources, and the social philosophy behind them in response to this population shift. The celebration of the establishment of the Graduate School of Niigata University of Health and Welfare (Niigata, Japan) on June 3, 2005 offered an opportunity to explore the geriatric populations and health and welfare resources in the United States as compared with those in Japan. Under the chairmanship of Prof. Kyoichi Sonoda (Department of Social Welfare, Niigata University of Health and Welfare), Prof. Kozo Iwasaki (Department of Social Welfare, Niigata University of Health and Welfare) compared conditions in Japan with those in the United States as presented by this author in a Commemorative Lecture. This paper expands on that lecture, and is published in hope of encouraging comparative studies and collaboration among nations and cultures in understanding and responding to the health and welfare needs of older adults.

We present here information on five selected topics relating to the health and welfare of older adults in the contemporary United States:

1. Population trends
2. Health and welfare care and funding
3. Primary, secondary, tertiary, and post-event prevention
4. Long-term care alternatives
5. Future trends and choices

1. OLDER ADULT POPULATION TRENDS IN THE UNITED STATES

(with contributions from Sarita Bhalotra, M.D., Ph.D.; Laurence G. Branch, Ph.D. and Kathryn H. Petrossi, Ph.D.; and Len Fishman)

Older adults are an increasing proportion of the population. In 2010 and again in 2020 there will be an acceleration of this trend as "baby boomers" (the result of the major increase in births from 1945 to 1955 when military personnel returned to the civilian population at the end of World War II-the "baby boom") reach the age of retirement (illustration 1). The figures at various times in recent history are:

1900=4%
2000=13%;
age 85 and older=2%
2030=20%
2050: age 85 and older=5%

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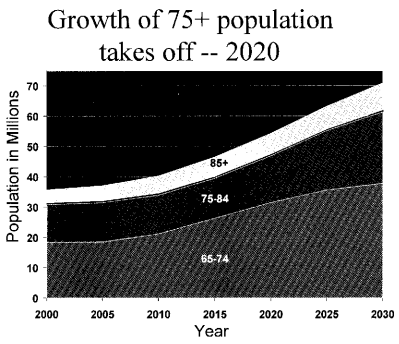
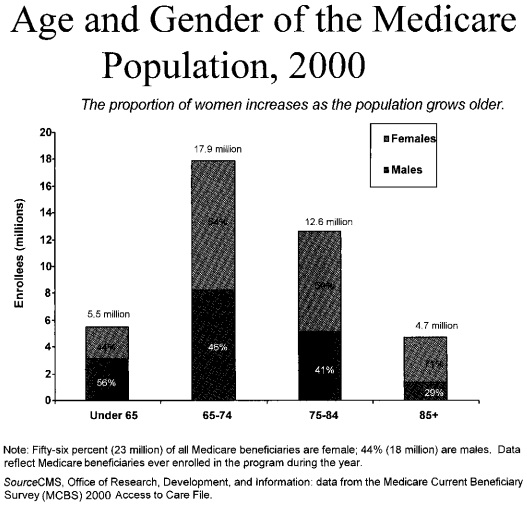


illustration 1

Due to higher mortality among males, females are an increasing proportion of the population (illustration 2).

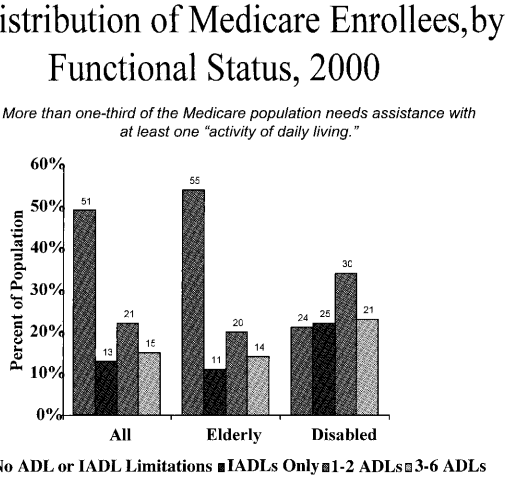


Note: Fifty-six percent (23 million) of all Medicare beneficiaries are female; 44% (18 million) are males. Data reflect Medicare beneficiaries ever enrolled in the program during the year.

*Source*CMS, Office of Research, Development, and Information: data from the Medicare Current Beneficiary Survey (MCBS) 2000 Access to Care File.

illustration 2

In terms of functional status, 21% of older adults are chronically disabled-24.9% of women and 15.5% of men. Perhaps the lower mortality rate among women preserves more disabled women than men. Illustration 3 shows disability rates among all Medicare enrollees, who include both older adults and younger people who are totally disabled (see Section 2). It is important to note the complementary evidence-that 56% of older adults have no disability, and only 14% have limitations of more than two ADLs (activities of daily living).



Note: ADLs are activities of daily living (e.g., eating, bathing); IADLs are instrumental activities of daily living (e.g., shopping, use of phone, deaning).
Soure: CMS, Office of Research,Development,and information: Data from Medicare Current Beneficiary Survey (MCBS) 2000 Access to Care File.

illustration 3

Not only are most older adults fully functional, but the rates of disability are progressively decreasing (see illustration 4). This is true especially of those with impairment of only one ADL — perhaps indicating that more healthy life styles maintain good health. There is also a striking reduction in rates of institutionalization —perhaps reflecting the increasing availability of alternative living arrangements (see Section 4) as much as improved health.

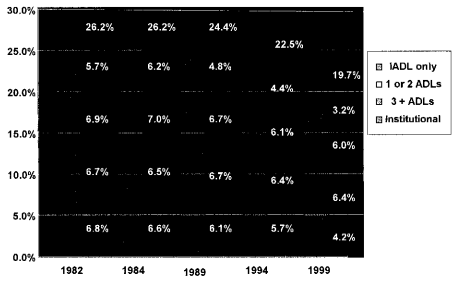


illustration 4

This last hypothesis is supported by the

findings that a large proportion of older adults with disabilities) even those with multiple disabilities remain living in settings other than institutions (illustration 5).

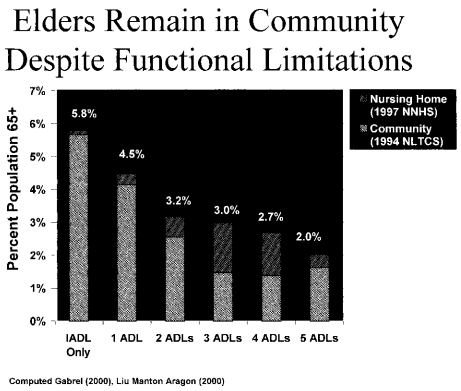


illustration 5

Older adults find a variety of living arrangements (see illustration 6). Despite public concern with the availability and cost of professional care, 65% live with family members. It is remarkable that 29% live alone. It is not surprising that 72% of these are women. It is striking that 56% are poor, with an income below $15,000 per year, and that 15% of this group are very old—aged 85 years or more. Again note that only 6% are institutionalized.

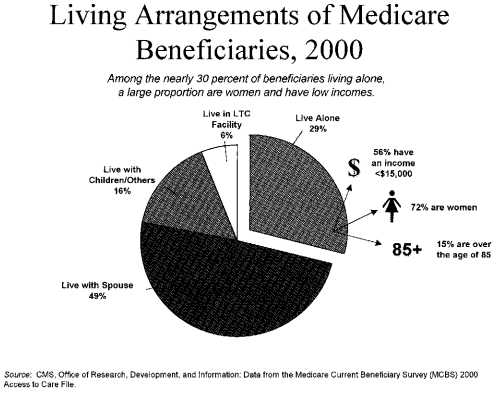


illustration 6

Older adults as a group are more likely to be poor than any other age group (see illustration 7). However they shared with the population as a whole the income gains during the economic "boom" years of the 1950's-1960's, and the 1990's. Their poverty level stabilized in the 15-25% range in the last quarter of the 20th century.

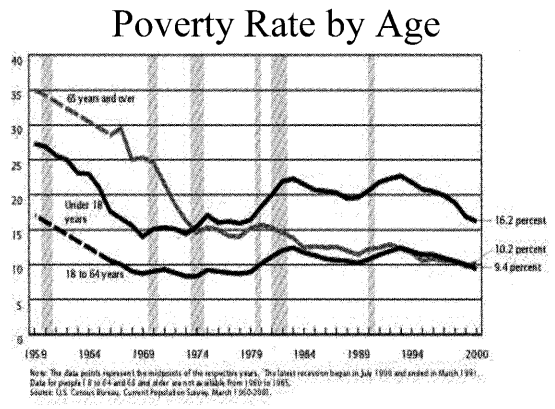


illustration 7

Exploring the economics of old age further, illustration 8 demonstrates that 58% of older adults have incomes under $20,000 per year. Since health care tends to be a fixed-price expenditure, it takes up a progressively higher proportion of lower incomes-up to 29% of the lowest category. (The policy implications for the support of health care are addressed in Section 5.)

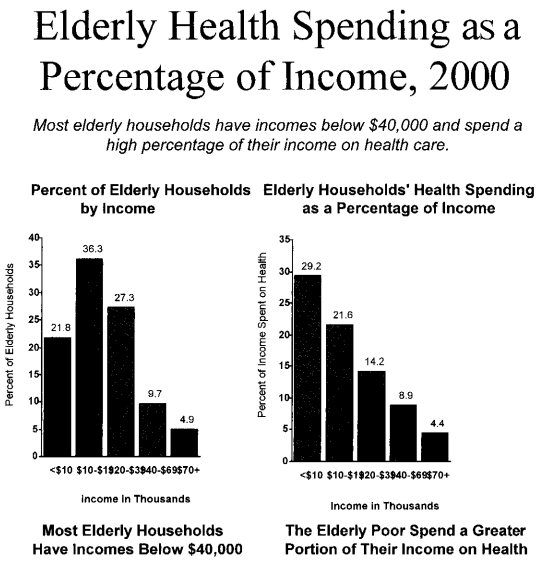


illustration 8

In another demographic aspect, the older adult population is increasing its educational attainments faster than are younger cohorts (see illustration 9). This has implications for the role of older adults in the society—perhaps promising more capacity to contribute than in past generations. This may be taken positively as a resource for society, or negatively as threatening dissatisfaction with their social role or competition with younger workers for jobs (see Section 5).

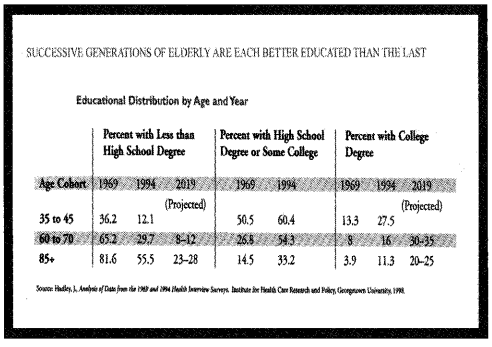


illustration 9

2. HEALTH AND WELFARE CARE AND FINANCING

(with contributions from Laurence G. Branch, Ph.D. and Kathryn H. Petrossi, Ph.D.)

The health care system can be studied in terms of access to health care, the quality of health and health care, and systems of payment for health care.

At the outset it is important to understand that health care has never been accepted as a right in the United States. There have been several attempts to mandate universal health care, and they have always been rejected:

1919 President Woodrow Wilson
1935 President Franklin Roosevelt as part of the Social Security Act
1939 Wagner Bill for a National Health Program
1950s President Harry Truman
1990's President Bill Clinton

The reasoning behind these rejections have probably been two: First, people are responsible for their own care and support, and should not depend on others (including their government). Second, health care is a commercial commodity —an "industry"—analogous to food and shelter, and the government should not intrude on or restrain free private enterprise in this aspect of the national economy. Thus, through U.S. history payment for health care has been a shifting mixture of personal, voluntary charity, commercial, local government, state government, and federal government sources.

Highlights of the history of health care in the United States can be outlined as follows:

a) From the time of the European settlement (and, in important ways, even today) the care of sick and needy people was undertaken by families, churches and religious groups, secular charitable organizations, and labor and unions and guilds. Towns and counties might offer shelter for the old, sick, and poor in alms-houses or poor houses. Local governments

also might choose to contribute money to the poor under the heading of "alms", "charity", or "welfare".

b) In the early days of U.S. independence — about1798 — the federal government established a system of collecting one shilling a month from merchant seamen's wages to support "seamen's bethels" to shelter sick and retired merchant seamen.

c) Following the U.S. Civil War (1860-65), the federal government established "soldiers' homes" for aged and disabled military veterans. This evolved into the U.S. Veterans Administration (see below).

d) In the late 19th and the 20th centuries, labor unions developed welfare trust funds to support needy (including old) fellow union members- "brothers and sisters".

e) From 1915 laws required employers to provide safety benefits for their workers.

f) In 1929 employees began to request deduction from wages for health care, which evolved into the Blue Cross and Blue Shield private health insurance plans.

g) In 1930 the U.S. Veterans Administration was established, coordinating pensions, medical services, long-term care facilities, etc. for veterans of the uniformed military services.

h) In 1935, during "The Great Depression", the federal government passed the Social Security Act, which included Old Age and Survivors' Benefits to help prevent poverty in old age. It is funded through payroll deductions and federal tax revenues.

g) During World War II employers began making health care insurance and retirement benefits part of workers compensation, because wage increases were prevented by wartime wage controls.

h) In 1945 the city of New York established the Health Insurance Plan of New York—the first government-sponsored prepaid health insurance plan in the United States.

i) In 1965 the federal government passed the "Mills Bill", establishing Medicare Part A to pay part of hospital bills, so that they would not impoverish citizens.

j) In 1965 the federal government replaced individual state welfare programs with a national system called "Medicaid", in which the federal and state programs contributed equally to support for the poor, including medical and long-term care.

k) In 1970 the Health Maintenance Organization Act encouraged the development of group health practices to coordinate health care, provide preventive services, and reduce waste and cost.

l) In1972 the Medicare program was expanded to cover younger disabled people and those with end-stage renal disease.

m) In the1980's long-term care insurance was developed to help pay the costs of long-term and custodial care.

n) In 2003 the Medicare Prescription Drug Improvement and Modernization Act ("Medicare Part D") further expanded the Medicare program to provide some payment for prescription medication and some screening (preventive) examinations.

Any review of resources for the health care of older adults in the U.S. must start with an important perspective: Most health care for older

Most Community-Resident Elders with Disabilities Rely on Informal Care

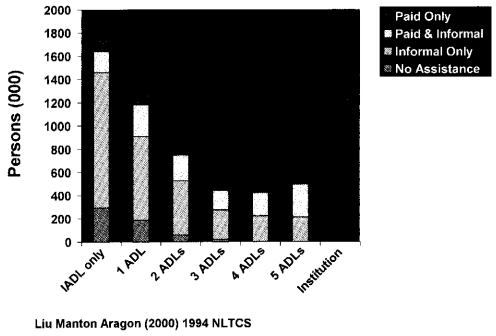


illustration 10

adults comes from family, friends, neighbors, and other unpaid caregivers (see illustration 10).

The largest source of payment for health care for older adults is the federal Medicare program, administered by the office currently called the Centers for Medicare and Medicaid Services (CMS). This is a health insurance program for people over the age of 65. Its purpose has never been to pay all medical bills, but originally to provide protection against catastrophic hospital costs which, in the past, could impoverish older adults. As of 2004, 41 million people, almost the total older adult population, were covered by this program. As noted above, in 1972 this program was expanded to cover people under age 65 who have certain disabilities, and people with end-stage renal disease. In 1995 this expansion covered an additional four million people.

Medicare Part A Benefits, which cover hospital costs, are funded by a combination of a tax on the payroll of the beneficiaries (those covered by the program) and general taxes paid by all citizens. It covers specific services (see illustration 11) based on hospital treatment and certain services that complete treatment of acute illnesses after discharge from the hospital. An additional service was later added specifically-hospice care.

Medicare Part A Benefits

Benefit	What Is Included
Hospital Stays	Semiprivate room, meals, general nursing, and other hospital services and supplies.
Skilled Nursing Facility Care	Semiprivate room, meals, skilled nursing and rehabilitative services, other supplies and services.
Home Health Care	Part-time or intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speech-language therapy, medical social services, durable medical equipment, and medical supplies.
Hospice Care	Symptom control and pain relief medications, medical and support services for those with terminal illness. Also short-term hospital and inpatient respite care.
Blood	Pints of blood received during a covered hospital or skilled nursing facility stay.

illustration 11

Non-hospital costs for outpatient care and physicians' services are covered by Medicare Part B. This is funded one-third by the beneficiary through monthly premiums adjusted for income (and thus not an equal right of all citizens), and two-thirds by federal general taxes paid by all citizens. This program, too, covers only specified services (see illustration 12)

Medicare B Benefits

Benefit	What Is Included
Medical and other services	Doctor's services (though not routine physicals), outpatient medical & surgical services and supplies, diagnostic tests, ambulatory surgery center fees, and durable medical equipment. Also surgical second opinions, outpatient mental health care, outpatient occupational and physical therapy.
Laboratory	Blood tests, urinalysis, some screening tests.
Home health care	Part-time or intermittent skilled nursing care, home health aides, physical and occupational therapy, speech language therapy, medical social services, and durable medical equipment.
Outpatients hospital	Hospital services and supplies received as part of care provided as an outpatient.
Blood	Pints of blood received during covered Part B services.
Preventive Services (if qualified)	Bone mass measurements, colorectal cancer screening, diabetes services, glaucoma screening, mammogram screening, PAP test and pelvic examination, prostate cancer screening, and vaccinations.
Other Services	Medically necessary ambulance services, artificial limbs, braces, chiropractic services for spinal subluxation , emergency care, eyeglasses, hearing exams, immunotherapy for transplant patients, kidney dialysis, diabetic foot exams, prescribed nutrition therapy, medical supplies, and organ transplants.

illustration 12

To repeat, Medicare was never intended to pay all medical care costs. Medicare sets the allowable fees for covered treatments; the patient is expected to pay part of these fees as deductibles and copayments. For instance, for outpatient treatment of medical illnesses, the patient is responsible for paying 20% of the Medicare-determined fee. For outpatient treatment of mental health illnesses, patients are responsible for paying 50% of the Medicare-determined fee (institutionalizing the societal prejudice against mental illness). And certain health care is not covered at all by Medicare (illustration 13):

Services Not Covered by Medicare

Long-term Care

Custodial Care

Dentures and Dental Care

Vision Care

Hearing Aids

Prescription Drugs (partly changed by a new and complicated benefit design)

illustration 13

This leads to the use of Medicare supplement or "medigap" insurance-sometimes called "Medicare

Part C"-to pay for Medicare deductibles and coinsurance, and for non-covered services. This can be done in several ways:

1. Patients may pay these costs out of their own earnings
2. They may purchase additional "medigap" insurance from private insurance companies, sometimes paid in part or entirely by employers as an employment benefit
3. They may join "Medicare+Choice" insurance plans, which replaces Medicare coverage as well as paying deductibles, coinsurance, and services not covered by Medicare. The services covered and other treatment policies are determined by the specific insurance plans within Medicare rules. These are funded in part by the Medicare Part A and B sources, and may require deductibles and copayments from the beneficiaries.

Medicare Part D is a recently added extension of the program to pay for part of the cost of some prescription medication. It is complex, not yet tried, and does not cover major portions of medication costs. Like Medicare Part B, it is funded by tax revenues plus monthly premiums paid by the beneficiaries.

Medicare expenditures have risen greatly since the start of the program. This is partly because of inflation, partly because of expensive new treatment methods (technology, medications, etc.), but also because of the increase in the older adult population needing health care. Sample total expenditures are:

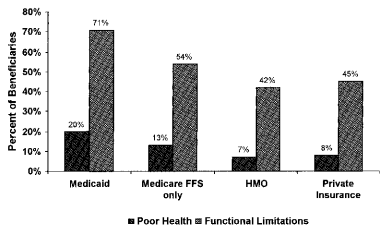
1967=$3.3 billion
2004=$300 billion
2013 (projected)=$530 billion

Medicaid, as mentioned before, is the program to care for the poor. It is funded half by the federal government and half by the individual states. Because the states pay half the costs they can decide what services to pay for and how much to pay for them within limits set by the federal government. Under Topic 4 we will address the importance of Medicaid as the main source of payment for long-term care.

There are also private health insurance plans —paid for by the beneficiaries—to pay for health care. However, this covers only a small part of the older adult population except as Medicare-supplement health insurance. Medicaid and Medicare (fee for service or FFS, rather than Medicare+Choice insurance plans) pay for most of the health care to the most disabled people in the country compared to Health Maintenance Organizations (HMO's) and private insurance plans (illustration 14).

Beneficiaries with Poor Health and Functional Limitations, by Insurance Status, 2000

Medicare beneficiaries in poor health or with functional limitations are more likely to receive Medicaid assistance or to have no supplemental insurance



Source CMS, Office of Research, Development, and Information: Data from the Medicare Current Beneficiary Survey (MCBS) 2000 Access to Care File.

illustration 14

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ADDITIONAL RESOURCES

1. Social Security Administration: 1-800-772-1213
2. www.medicare.gov to find information about eligibility, benefits, premiums, which personal plan is best for you, and quality information.

3. PRIMARY, SECONDARY, TERTIARY, AND POST-EVENT PREVENTION

(based on contributions from Sarita Bhalotra, M.D., Ph.D.)

Health care may be seen from the perspective of prevention or that of cure:

"The role of (acute) medical care in preventing sickness and premature death is secondary to that of other influences; yet society's investment in health care is based on the premise that it is the major determinant. It is assumed that we are ill and made well, but it is nearer the truth that we are well and made ill."

McKeown, T., "The Role of Medicine: Dream, Mirage, or Nemesis?" (Princeton, NJ: Princeton University Press, 1979)

The leading causes of morbidity and mortality include heart disease, cancer, cerebrovascular disease, chronic lung disease, diabetes, chronic liver disease, and depression. All of these are influenced by modifiable risk factors, including abuse of tobacco, alcohol, and drugs; inattention to diet and physical activity; the misuse of toxic agents, firearms, and motor vehicles; high risk sexual behaviors; and an imbalance of psycho-social needs vs. material needs. Thus, there is the potential for compression of morbidity and disability, with consequent improved quality of life accompanied by cost saving.

Prof. Sarita Bhalotra has suggested the addition of a fourth category to the usual set of public health prevention categories, as follows:

Stages of Prevention

Primary Prevention: occurs before illness

consists of health promotion activities, such as health education; wellness promotion; good nutrition; exercise; adequate housing; stress reduction; and avoidance of alcohol, drugs, and tobacco

specific protections are also required, such as immunizations, accident prevention, use if automobile seat belts, and reduction of risk factors

Secondary Prevention: occurs early in illness

consists of early diagnosis and effective treatment

Tertiary Prevention: occurs after the treatment of illness

consists of reduction of disability and stabilization of function

Post-Event Prevention: continues through secondary and tertiary prevention

consists of continuation of health promotion and specific protections to prevent recurrent illness and further disability

The process of aging includes both psychological adjustment to changes and effective physical functioning. Contributors to the aging process are both

a) intrinsic factors difficult to change, including genetics and structural deterioration

b) extrinsic factors which can be changed with prevention effort, such as healthy behavior, and avoiding risks and damage

Primary and Post-Event Prevention methods include exercise, nutrition and weight control, avoiding substance abuse (such as tobacco, alcohol, and drugs), stress management, and avoiding high risk behaviors (such as unsafe sex, dangerous automobile driving, and extreme temperatures).

Primary and Post-Event Prevention can be accomplished through public education and health-promotion programs.

Primary and Post-Event Prevention can also be accomplished through change in the focus of the health care system from secondary to primary prevention. Medicare was designed for secondary prevention and originally to pay for hospital treatment. In 1997 the Balanced Budget Act added some prevention and early diagnosis services, but only those for which there was considered to be evidence of effectiveness-mammograms, prostate cancer screening, influenza immunization, bone density testing

(for osteoporosis), colorectal cancer screening, diabetes services, glaucoma screening, PAP (Papanicolau) testing for cervical malignancy, pelvic examinations, and immunization against influenza and pneumonia.

Several alternative health care models have been developed by public and private groups which are interested in more effective, comprehensive, and/or financially economical health care for various populations. They are currently receiving critical evaluation and comparison. Some of them are listed in illustration 15, each with a reference in which it is discussed in detail:

ALTERNATIVE HEALTHCARE MODELS

- **Wagner Chronic Care Model** (Wagner, E.H., Davis, C, Schaefer, et al.(1999): A survey of leading chronic disease management programs: are they consistent with the literature. Managed Care Quarterly, 7(3), 56-66)
- **Chronic Disease Self-Management** (Von Korff, M, Gruman, J, Schaefer, J,et al(1997): Collaborative management of chronic illness. Annals of Internal Medicine, 127(12), 1097 – 1102; Glasgow, RE, Funnell, MM, Bonomi, AE, et al.(2002): Self-Management aspects of the improving chronic illness care Breakthrough Series: Implementation with Diabetes and Heart Failure Teams. Annals of Behavioral Medicine, 24(2):80-87)
- **Senior Wellness projects**
- **Progam of All-Inclusive Care for the Elderly (PACE)** (Williamson, J.D. (2000): Improving care management and health outcomes for frail older people: implications of the PACE model. JAGS, 48, 1529-1530)
- **Social HMOs (SHMO)** (Leutz, WN., Greenlick, M, et al.(1992): Adding long-term care to Medicare: The Social HMO Experience. Journal of Aging and Social Policy, 3(4), 69-87)
- **Geriatric Assessment Programs** (Stuck AE, Siu AL, Wieland, D, et al. (1993): Comprehensive geriatric assessment: a meta-analysis of controlled trials. Lancet, 342: 1032-1036)

illustration 15

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4. LONG-TERM CARE

(information from Mr. Len Fishman)

In the past long term care environments for older adults expanded from family homes to public protective facilities to professionally administered nursing homes. In recent years older adults and their families have pressed for a broader range of alternatives more attuned to the wish for community living within the limits imposed by disabilities. These include:

congregate housing—where disabled people live together for mutual support

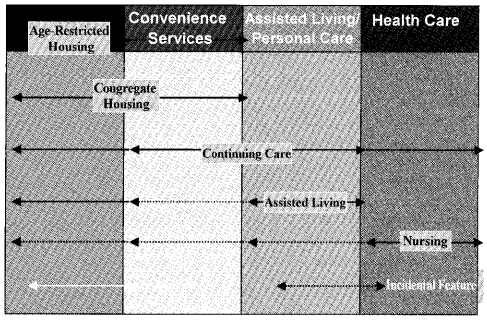
continuing care—where people receive skilled nursing care after hospitalization

assisted living—where people live independently but receive supportive services

nursing home—where people receive intensive nursing care at all times

The range available at present is presented in illustration 16:

Overview of
Senior Living Continuum



Source: NIC's National Supply Estimate of Senior Housing and Care Properties.

illustration 16

As the geriatric population grows and the costs of medical care increase, the cost of long term care has and will increase exponentially. Illustration 17 shows the contribution of various funding sources to this growth:

Institutional LTC Spending
Congressional Budget Office Projections

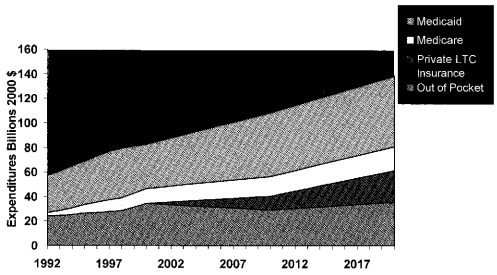


illustration 17

As mentioned in Topic 2, Medicaid is the main source of funding for long-term care, with some contribution from private long-term care insurance (developed relatively recently) and Medicare payment for short-term rehabilitation after hospitalization in "sub-acute" care facilities. Illustration 18 shows the use of Medicaid funds, with 20.4% used for chronic care in nursing homes.

LTC is 35% of Medicaid
Spending

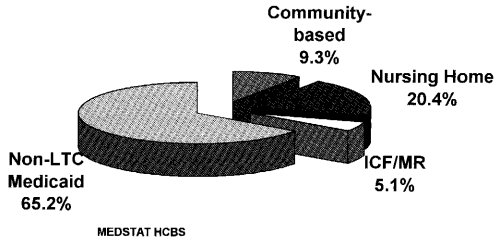


illustration 18

Conversely, illustration 19 shows that nursing homes are much more dependent on Medicaid funds (49%) than are non-long term care health services (18%).

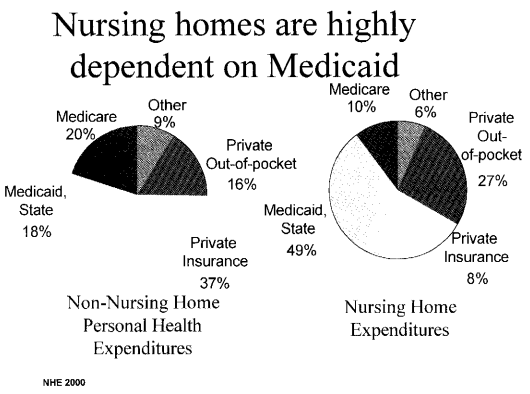


illustration 19

However, Medicaid funds are severely limited by state as well as federal governments, to the point that they do not pay the costs of nursing home care (illustration 20). It has been noted that government-imposed minimum standards for nursing home care become the maximum care given, since nursing homes are not funded to give more care. Thus, it is financially difficult to administer nursing homes, and large corporations, which purchased and built nursing homes as a way of earning great profits from the growing geriatric population, have found that they are losing money, and sell the nursing homes or go bankrupt.

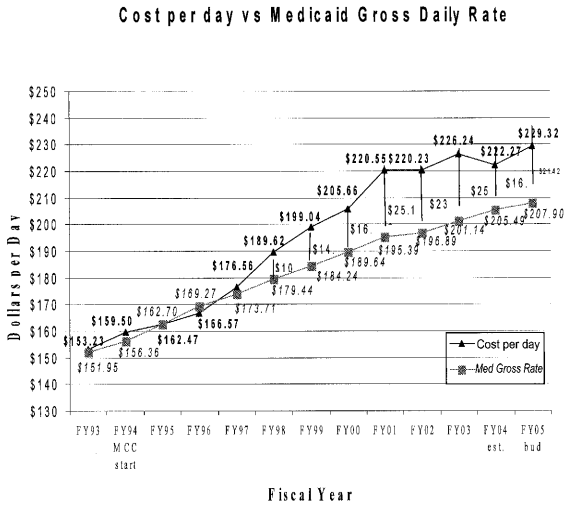


illustration 20

One large long-term care organization, Hebrew SeniorLife in the Boston, Massachusetts area, has spent much time developing a strategy to deal with these changes in long-term care financing, people's desire for care located in the community rather than in institutions, and the shift of the geriatric population from the city to the suburbs. Len Fishman, its president, reports that their plan is to establish a continuum of services and settings to address:the population which Hebrew Senior Life is responsible for and which their financial support for the new kinds of long term care these people want

finding money to support these new long term care services by balancing income from residents who pay for their own care at market rates with government subsidized reimbursement.

The evolution from a nursing home to a constellation of diverse resources is shown in illustration 21 (note "SNF" means "skilled nursing facility"):

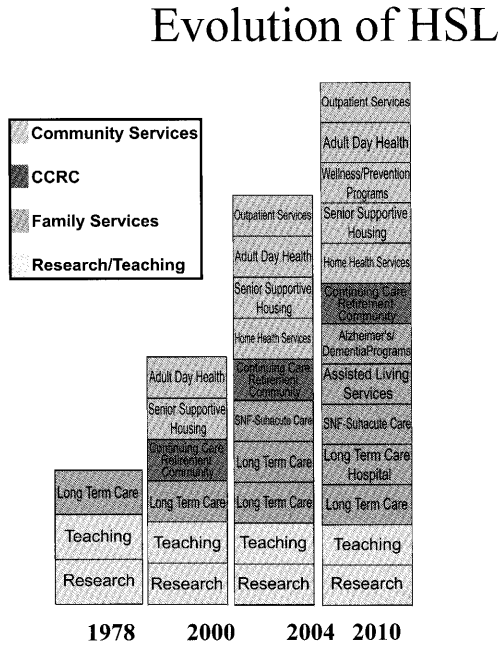


illustration 21

The varied facilities in the Hebrew SeniorLife constellation are as follows:

1. The Roslindale Campus (illustrations 22 and 23): It was the original nursing home (The Hebrew Home for the Aged, which became The Hebrew Rehabilitation Center for Aged). Now it includes
   650 beds nursing home
   25 beds acute medical care
   25 beds recuperative/rehabilitation care

Roslindale Campus

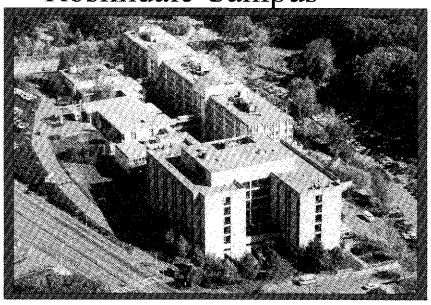


illustration 22

Roslindale Campus

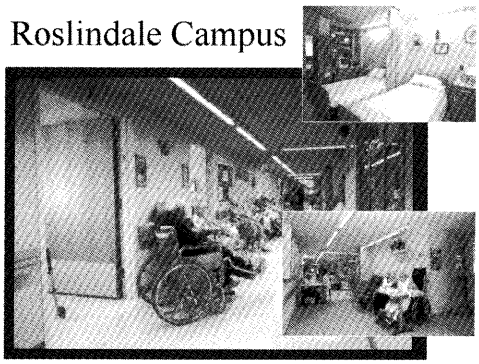


illustration 23

2. Jack Satter House (illustration 24): A 266 bed independent living facility, providing an evening meal and emergency services

Jack Satter House, Revere

illustration 24

3. Simon C. Fireman Community (illustration 25): A 179 bed independent living facility, which offers an evening meal and emergency services.

Randolph

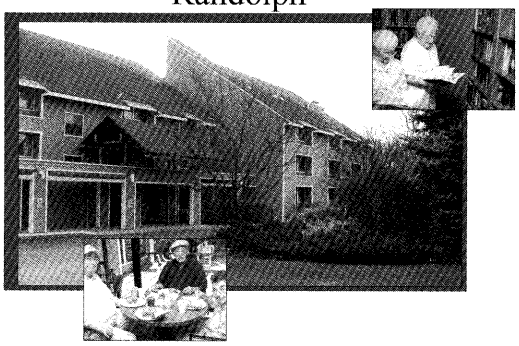


illustration 25

4. Center Communities of Coolidge Corner and Brookline (illustrations 26, 27, and 28): Three facilities with a total of 517 beds, offering independent living with more services — meals delivered to rooms if needed, a nurse practitioner part time and physician visits, an activities director full time and activity program, and a fitness director full time and a gymnasium for exercise. In the building are 208 beds for frail older adults, who are given lunch and dinner daily.

Center Communities of Brookline, Coolidge Corner

illustration 26

100 Centre Plaza

illustration 27

Center Communities of Brookline 1550 Beacon Plaza

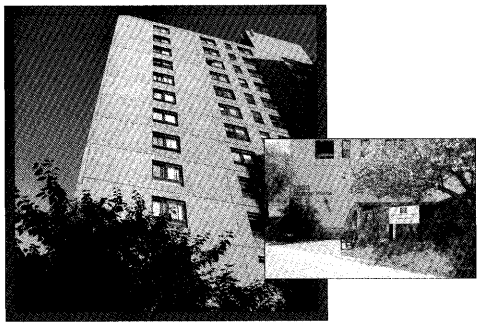


illustration 28

5. Orchard Cove (illustration 29): A continuing care retirement community (CCRC) providing a full range of care, so that residents whose health deteriorates progressively can move from one level of care to the next without leaving the home facility or having to negotiate admission to another facility. It includes 260 beds of independent living, 25 beds of assisted living, and 25 beds of skilled nursing care.

Orchard Cove, Canton

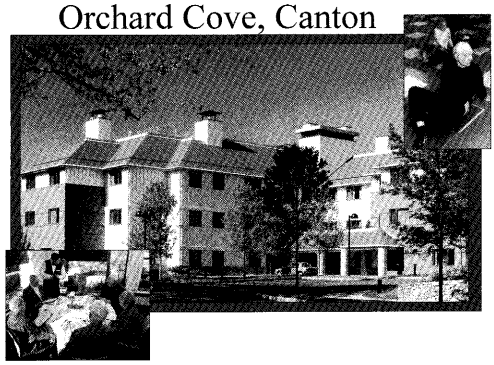


illustration 29

6. A new campus is being organized to include supportive housing for older adults needing limited help, assisted living for those needing a greater level of help (including a facility for those with dementia), and a health care center for those needing skilled nursing care.

Campus Organization: Five Distinct Senior Programs

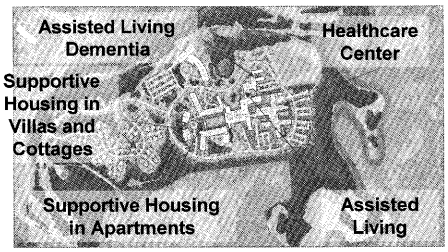


illustration 30

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5. FUTURE TRENDS AND CHOICES IN HEALTH AND WELFARE SERVICES

The information presented in this paper reveal several trends in the geriatric population in the United States:

a) The population as a whole is healthier. That is, there is steady progress toward the ideal of delaying the onset of disability until later in life. Illustration 31 diagrams the ideal of "squaring the curve" of age vs. disability.

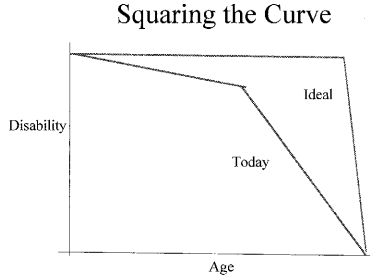

illustration 31

b) An increasing proportion of the older adult population is living in the community rather than in institutions. Len Fishman has provided a diagram (illustration 32) of the change in the kinds of health and welfare services they need.

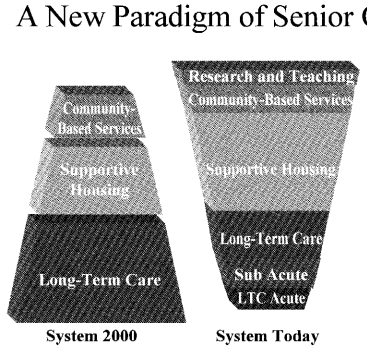

illustration 32

c) The result is that these healthier older adults, who are neighbors of younger people in the community, are more active participants in society. This has is good and bad implications:

older adults are less of a burden on the younger workers in the society

older adults, in search of productive activity, compete for jobs with younger workers

These trends require adjustment of the politico-economics of older adult support and of the job market. And, as is often the case, politico-economic issues reflect issues of social values. The society must decide:

a) How important are the health and functioning of citizens compared to other needs (such as industry, material infrastructure, defense, etc.)?

b) How important are older adults compared with other citizens (children, adult workers, etc.)?

c) What is the political power of older adults and those interested in them to influence political and economic decisions in terms of allocation of resources?

d) Is health care

a right of all citizens and the society's responsibility to provide it through its government, or

a consumer service bought by individuals with the money they earn from people who sell it for a profit?

e) Is the society ready to move health and welfare

service
from secondary and tertiary prevention
to primary and post-event prevention?

f) In health care is the primary concern for
biological functioning (physical health), or
psychological functioning (emotional and cognitive health) or
social functioning (satisfying roles and relationships)?

There have historically been no clear decisions about these social policies, because in the United States democratic society there is not consensus about them. There are those politically oriented to the freedom of individuals from the control of authorities, and to allowing people to set their own goals and limits—the "libertarians". There are those dedicated to the benefit of their own businesses, professions, and geopolitical territories, and opposed to governmental or societal interference, except when it supports or protects their interests—the economic and social "conservatives". There are those dedicated to meeting the needs of people, protecting them from injury and exploitation, and encouraging the realization of their human potentials—the "liberals". And there are those championing narrow causes because of their personal experiences—advocates for special problems and populations. The history of policy-making in the United States is one of advocates, lobbies, pressure groups, campaigns, influence, and pressure from competing groups. These seek to influence all aspects of government, including the selection of government officials, the scope of government power, legislation, and executive policy so that it will favor their specific goals and the concepts of government that will support those goals. The result has been mixed and shifting policy relating to health and health care. Even the longest existing of government health care policies—the Veterans Administration and the Social Security system and Medicare—are now caught up in political battles between those supporting government responsibility for the health of the nation, and those who believe in individual citizens' responsibility for caring for their own health and welfare.

The United States has some of the most advanced health care knowledge, technology, research, and expertise in the world. However, its health care system is inconsistent, fragmented, inefficient, and costly. The high level of health care is available to certain elements of the population, while others do not have access to it because of cost, geographical location, or, there is some evidence, prejudice against some sub-populations. And the system heavily emphasizes secondary prevention—the treatment of acute illness—rather than primary or post-event prevention. The great increase in the older adult population has forced attention to their health and welfare needs; and their economic, social, and political implications. However, they face the same health care system as other population groups.

Despite general agreement about the defects in the health care system, and despite a large array of detailed plans for the health and welfare of older adults and convincing argument and data to support them, most people do not expect a clear and effective plan to be agreed upon and implemented in the near future. This is a testament to the conflict between the national characteristics of sympathetic concern for people in need, innovation and vigor, and individuality and resentment of authority. Can the democratic political system, which guarantees a voice to all groups and ideas, harmonize them into an effective policy and practice to deal with health and health care for older adults and for the society as a whole?

EPILOGUE

I am indebted to Prof. Sarita Bhalotra for an illustration of the sturdiness of the individual

older adult (illustration 33). Through the window of a railway train in India she observed an old man who had the physical capacity to climb a tree stump, the mental vigor to be interested in the newspaper, and the spiritual tranquility to be undisturbed by the tumult of the railway train. Perhaps he has achieved considerable "squaring of the curve" in his complex culture.

illustration 33