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Urban Designed Programs for the Rural Elderly: Are They Exportable?[1]

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There are a variety of problems that affect older people in rural areas. In the first part of this paper, we examine four problems affecting the rural aged in particular: health, income, housing and social integration into rural communities. In the second part of the paper, we examine the question of whether programs to deal with these problems that have developed in various cities in the United States can readily be translated into rural communities. The paper concludes with a warning that the urban crisis, largely discovered by human services and other urbanists in the 1960s, is increasingly being expropriated as an issue by those whose primary concerns are reducing public spending and limiting local basic public services in both urban and rural areas.

I. Characteristics of the Rural Aged

Approximately 27 percent of America's elderly population – one in four – live in rural areas. These older people experience physical, psychological and social problems comparable to those aged living in other, more urban areas. Unlike the urban aged, however they often do not have access to well-developed social service systems to ameliorate their problems. In this paper, some of the characteristics of the rural aged will be discussed. In addition, social programs often found in urbanized areas will be examined with regard to their potential usefulness for rural areas.

Of the elderly persons living in rural areas, 6.5 percent live in nonfarm or farm situations within a metropolitan areas (Bureau of the Census, 1974, 15). As Sheldon (1967: 126-127) has indicated, "ruralness" can have a variety of meanings for older people and others ranging from the retired farmer living in an unincorporated town a few miles from a major metropolitan areas to the farmer or rancher living hundreds of miles from the nearest metropolitan area. In the first instance, rural residence may connote nothing about access to organized social services. The farmer living on the outskirts of a metropolitan area may have almost as easy access as a metropolitan resident. In the other case, however, rural residence may be equated with the absence of social services. Thus, when we talk of social services for the rural aged, we are dealing with access and lack of access to services that may be arranged almost along a continuum. The above mentioned statistical data would suggest that most rural aged are in situations where social services are not likely

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readily available. However, the realities of social services for the rural aged are not so easily described. Currently, a significant minority of older persons may have as easy access as the typical urban dweller.

There are a variety of problem areas that affect many aged people without our society, regardless of residence. Before dealing with programmatic areas, it would be appropriate to describe these problem areas. It should be noted that source after source makes no distinctions between the needs and problems of the rural aged and those of the urban aged (Rose, 1967; Britton and Britton, 1967; McKain, 1967). Instead, sources in social gerontology point more to modest variations on the same theme when comparing the rural and urban elderly. Although there may be slight differences between these two groups, there are likely more similarities than dissimilarities. There are however fairly substantial differences in the ways in which social programs can be organized and delivered in rural and urban settings, and these differences will be dealt with later in this paper.

Health

Among the problems experienced by the aged everywhere are the difficulties created by declines in physical health levels. Although in theory it is possible to distinguish clearly between aging and disease, illness and disability are still the fate of very large numbers of older persons. Nowhere is this more true than in contemporary rural Appalachia. Such declines mean, for example, that the older rural population is on the whole less healthy and less active than the young rural population. We know also that physical decline and disability are primary determinants of early retirement from the workforce (Thompson, 1971). Thus, the health status of an older person is also likely to have a marked impact on the overall quality of post-retirement life.

Not all persons over the age of 65 have serious health problems or mental or physical impairments, by any means. However, an estimated 85 percent of this population does have at least one chronic disease or condition (including arthritis, asthma, diabetes, cancer, heart disease or stroke). Workers in rural occupations like mining are particularly subject to particular forms of chronic disease such as black lung, silicosis or emphysema which often contribute to premature aging and death. Agricultural workers may be more subject than other workers to skin cancer, for example, from longer than typical exposure to the sun.

In general, however, it is difficult to make any global generalizations about rural and urban health differences without also noting important exceptions. To the extent that tension and anxiety are primary factors in heart disease, for example, then one might think the peace and tranquility of small town life might contribute to greater longevity, but there is little evidence that this is the case. People in rural areas do not, on the whole, tend to live any longer (or shorter) lives than their contemporaries in the city.

Income

The income differences between rural and metropolitan America for the population as a whole are both very real and very significant, but they also parallel to some degree important differences in the cost of living. Thus, in considering the income problems of the aged we have not only to ask where income is higher (or lower) but also how any differences correspond to cost of living differences. For lower incomes for rural aged persons in rural areas could be ameliorated to some degree by lower cost of living levels (requiring, in effect, less income for the same quality of life).

It is significant that while both income and cost of living levels generally tend to be higher in metropolitan regions, much of the income components most significant for the rural aged are uniform nationally (Statistical Abstract, Table #538. 581). Social security payments do not take residential status into account, which has the net effect that social security recipients in rural areas are slightly advantaged over their metropolitan counterparts with comparable incomes that enable them to buy somewhat more with them. The same would appear to be the case for recipients of Supplemental Security Income (SSI) payments which replaced the depression-era, means-tested and highly variable state and local Old Age Assistance (OAA) programs in 1974. Thus, if rural aged are less well off than their urban counterparts, it would be for reasons other than these two considerations, which together account for a substantial portion of the aggregate income of the aged. This does not mean that other important differences do not exist, however. For example, it is likely that a greater than proportionate percentage of aged persons not covered by social security reside in non-metropolitan areas, since this is still where the bulk of non-covered jobs still exist. Further, to the extent that there is a relationship between location and size of employer and the likelihood of an adequate pension or retirement income plan, it may also be the case that retired workers in non-metropolitan settings are more likely to receive fewer or smaller pension payments or none at all. Finally, whether they are urban or rural, it is likely that those who live in states with historical patterns of deficiency in public assistance, food stamps, Medicaid and public housing will be victimized to a greater degree than those living in states with histories of adequate performance in those areas. Existing data, however, fail to show any significant relationships between these patterns and the region or degree of urbanness of such states during the current decade (Lohmann, 1974).

Housing

Housing is an even more difficult area than income in which to capture the significance of any existing differences between urban and rural aged persons – largely because of the tremendous difficulties suggested by the intervening influence of any individual's "satisfaction" with their housing arrangements. Consequently, much argument in this area is constructed to fit people's personal preferences and even prejudices. Obviously, if you compare the newly constructed suburbs of any metropolitan city in America with the decades-old rural shanties of which there are still an abundance in rural America, it is abundantly clear where

the problem resides. On the other hand, comparing the slums of New York, Chicago, Omaha or Los Angeles with the neat, clean and tidy bungalows along main street in most small towns produces quite the opposite conclusion.

The major point here, however, is that deficient, deteriorating and dilapidated housing is to be found everywhere in the United States and the continued operation of "trickle down" effects in housing markets means that both the urban and the rural elderly poor and other poor age groups must compete for the oldest, and most deficient housing available in most housing markets. It is also the case that a sizable number of older people in both cities and rural areas continue to occupy the safe, convenient, and comfortable housing in which they raised their families and a small minority of the most affluent are able to relocate to luxury housing. While not a completely adequate solution, public housing for the aged does appear to have gone a long way toward ameliorating the most serious housing problems of a great many aged persons in those rural communities where such housing has been constructed. However, current efforts in Title XX and elsewhere to keep people out of institutions may also suggest the need for greater commitment to home maintenance and repair programs, as well as nutrition, home health and other supportive services.

Social Integration

Of all the problems faced by the rural aged, the one which occupies the most critical position is also the one most frequently passed over by existing service delivery systems – urban and rural alike. That is the degree of social integration experience by older people. Two interrelated questions must be raised in this context. One concerns the degree of social involvement – in family, friendship groups, church and community organizations. To the extent that such social involvement and contact is low – in rural areas or anywhere else – the problems of loneliness, social isolation, alienation and more serious mental health problems of depression, paranoia and other conditions may be present. This might be seen as the *problem dimension* of social integration. The other – *solution* – dimension has to do with the degree to which existing social relationships, no matter with whom or under what circumstances afford the kind of personal support, assistance and help which enable satisfactory living conditions for the elderly person. To the extent that such mutual aid relations are available, not only is it likely that an aged person will be less lonely or disoriented but also that any problems of poor health, low income or deficient housing will be easier to cope with.

Old age is also a time when a great deal of adjustment to changes in life circumstances are required. Children leaving home, retirement, deaths of neighbors, friends and family, decreased personal mobility and other factors may need to be confronted and dealt with. In such cases, the mutual aid of existing or newly created social relationships should be seen as the first line of intervention with organized services as activities and respite services as secondary (and often a poor second at that).

Needs Summary

In brief, the needs of older persons living in rural areas are not significantly different than the needs of older persons living elsewhere. They get hungry, sick, lonely, they need love, kindness and attention. Their windows break, their leaves need to be raked, their lawns mowed, and their roofs sometimes leak. And often their Social Security checks and any other income (which most don't have) don't stretch to the end of the month. Unlike their urban counterparts, however, most older people in rural areas are safe from the beatings, muggings, rapes and other violence which are the particular curse of those trapped by the radical transformations of some older inner-city neighborhoods.

II. Are Urban Services Exportable?

There are a variety of services that have been developed in urban areas to deal with the above mentioned problems. Some of these services and programs are available regardless of geographical location Others tend to be geographically bounded or have been utilized in rural areas in ways that are not appropriate.

Health Services

Medicare and Medicaid are the primary health care programs that affect older people nationally. They are not limited in coverage by geographical area, although the latter tends to vary by state. Even though questions are currently raised about both the comprehensiveness of coverage of these programs and the cost to the consumer, the programs have eliminated much of the concern about the financial access to medical care which distressed older people before their adoption in the mid 1960s. However, provision for the financing of medical care does not guarantee the availability of medical care leaving all older people to some extent, and in particular older rural people especially vulnerable. Although the National Health Corps has attempted to deal with this problem, many rural areas still lack sufficient medical personnel and services.

Even when a doctor is present, older people in both rural and organ areas may not have as easy access to good medical care as do younger people. Many doctors prefer not to treat older patients for a variety of reasons including the red tape involved in obtaining reimbursements from government programs. In addition, too many medical personnel are poorly trained in the care of the elderly, a subject which is sadly neglected by medical schools. Thus, even when physical and financial access to medical care are theoretically available, that care many not be of the quality and sensitivity it should be.

Other health-related programs sometimes found in urban areas today may include limited detection programs, such as high blood pressure screening or cancer detection units, or prevention programs such as physical exercise or dietary screening. Although these programs are probably not as widespread in most rural

areas as urban ones there seems to be no inherent reasons why they would not be applicable to rural settings and helpful to rural people.

Retirement Income Programs

The basis of most income problems of older people stem from retirement from the labor force; retirement drastically affects the income of retirees regardless of geographic location. Often retirement income is reduced to fifty percent of the level of pre-retirement pay. Income maintenance programs are increasingly becoming the province of the federal government and of private pension plans because of the prohibitive costs involved. Particularly since the implementation of Supplemental Security Income (SSI) programs for the old, blind and disabled in 1974, the provision of income support for a low income older person is no longer dependent upon the financial limitations or political commitments of individual states. SSI payments and benefits under the Older social insurance programs of Old Age Survivors and Disability Health Insurance (OASDHI) have established a minimum benefit level applicable nationwide. Older people in rural areas may actually be in an advantageous state with regard to income as SSI benefit levels are constant even though costs of living may not be. It should be emphasized, however, that this minimum is precisely that: a minimal level of income. Although the number of older people living in poverty immediately and dramatically declined after the implementation of SSI, sixteen percent of older people nationally remain below the poverty level (Department of Health, Education and Welfare, 1975). For those residing in non-metropolitan areas the figure is somewhat higher – 22.5% (Bureau of the Census, 1974, 37).

There are few other income support programs in either urban or rural areas other than those sponsored under federal legislation. These are discount programs operating in both types of areas which attempt to increase the buying power of older people. Such discount programs typically have a minimum age of 65 and cover both drug purchases and soft goods, such as clothing. In addition, cooperatives are being formed in increasing numbers to increase the buying power of older people and other age groups. Older rural people in many states may have an advantage over their urban counterparts on this point since the strongest cooperatives in the United States have traditionally been in rural areas.

There are also increasing efforts to use the talents of older people to develop marketable products. Here too rural older people are likely at an advantage since it is more probably they have retained skill in many of the crafts being marketed. Older members of black, native American, Chicano and other ethnic or sub-cultural groups may be in an especially advantageous position here as carriers of skills and crafts all but unknown in the outside (non-ethnic) society.

Housing

The housing needs of older people are probably being met with less adequacy than are the needs of their urban counterparts. Analyses of census data on housing indicate that older rural people are more likely to live in dilapidated or deteriorating housing than older people (Lohmann and Lohmann, 1970). Also, older people as a whole are less likely to live in adequate housing than are members of younger age groups. Although the U.S. has had decent housing as a national goal for more than two decades, that goal is still far from being met, especially for older people. Federally funded housing programs have attempted to increase the amount of decent housing for older people. Such programs are often more available in urban areas where the local government has the necessary expertise to apply for federal funding. Even when federal housing programs have been used to increase the housing stock for older rural residents, such programs have often been used inappropriately or in a questionable manner. The presence of a multi-story high rise in a rural community of one and two story homes may fit HUD design specifications, but its "fit" in the community is another question entirely. Often the only structure of comparable height may be the local grain elevator or coal mine shaft entrance and only rats live there. In rural communities, as in all other settings, attention needs to be paid when constructing housing not only to the cost per square foot but also to the appropriateness of the structure given the local setting and customs.

Recent efforts to upgrade the quality of existing housing stuck have also been focused upon older people. Such efforts are often coordinated and financed through a local Community Action Agency and thus are theoretically national in coverage. In practice, it is likely that many of the same services which are delivered in an urban area through an "Operation Fix-Up Program" are done through the mutual aid network in rural areas.

Social Integration Programs

One of the areas of greatest concern with regard to the rural aged is their possible social isolation. Unlike their urban counterparts, rural older people may live great distances from neighbors and others with whom they could socialize. Several social services have been designed to help meet the friendship needs of older people; among them are senior centers and friendly visitor programs. Senior centers are found in both rural and urban areas today. Rose (1967, 17) indicated that his experience with rural and urban senior centers in Minnesota suggested that rural centers might attract a greater proportion of their potential clientele – to fifty percent in some instances, compared to urban attendance in the range of from 1-5 percent (Riley & Foner, 1958, 508). However, since there are few if any studies comparing attendance at such centers by geographical location, we cannot be certain how accurate Rose's impressions are, although they do coincide with our own experience. It is probably that the rural center will be forced to be more multi-purpose than its urban counterpart. The relative absence of other social service agencies will likely mean that the rural center will serve not only as a socializing

center but also as the site of health screening services and the visit of Social Security representatives and other uses as well. Rural centers are likely to be forced to serve several purposes and unlikely to be limited to narrowly defined services and activities.

Programs like friendly visitors are perhaps less likely to be found in rural areas. However, the absence of an organized program does not indicate that a comparable services is not available. It probably means that this particular activity is being cried out through informal means rather than through a formal organization. In the rural area, it is more likely the members of a choir circle who do the visiting rather than the volunteers or employees of a social service agency.

Other Social Programs

In addition to the above programs and services there are additional programs often found in urban areas. The first of these is Mobile Meal or other nutrition programs. Although at present this service is more likely to be found in urban than in rural areas, it would seem also to be a program that is exportable to rural areas. In most rural areas the facilities for the preparation and serving of means would already be available in local churches or schools. The difficulty of obtaining funding for such programs might be the major limit on its use in rural areas. The difficulties posed by transporting meals to those homebound would also be more complex in many areas, since the efficiencies made possible by the concentration of recipients in urban areas would not be present in some rural farm areas.

Transportation may be a problem for rural and small town older people for which current urban solutions are not exportable. Cut-rate bus fares for older people are generally not a solution for communities with no buss service. Taxi programs are also not a solution if no taxis system exists. There have been innovative rural programs using vans on either a specified route or call system to provide transportation. Such programs are often expensive but have been developed in some areas through the use of cooperatives (*Aging,* 1972, 10-11).

Efforts to distinguish between rural and urban areas in the handling of the problems of the aged are largely an expertise in futility. Certainly, very large and crucial differences may be identified between particular urban areas, say Gross Pointe, Michigan or Newton, Massachusetts, and particular rural areas like Jellico, Tennessee or the Pine Ridge Reservation in South Dakota. However, there is no reason to assume that these differences which exist within these categories of *urban* and *rural* areas are either greater or lesser than the differences between categories. The retired and disabled worker or the “senile” widow, whether living alone on the streets of Boston or in a wooded Appalachian hollow may have considerably more in common with each other than with their urban or rural counterparts in suburbia or a “progressive” farm community with an extensive service delivery system for older people.

The key question in understanding the condition of older people in both urban and rural America today is essentially one of *resource availability* rather than location. Historically the recognition of human needs and wants and efforts to deal with such problems in an organized manner through services was a distinctly urban phenomenon – particularly in the cities of the Northeast and Midwest. However, the "urban values" underlying such services have, by the third quarter of the twentieth century been transmitted throughout the nation, so that older persons in all areas of the country, with few exceptions (both urban and rural) are equally interested in long and meaningful lives, education, good health and a sense of well-being. The problem now is the gap between these values and the existence of human service institutions to adequately deal with them. Consequently, the rural/urban dichotomy becomes meaningful in the case of the aged only in the context resource availability and access. We frequently use the terms rural and urban when what we really mean is resource-poor and resource-rich.

But such a distinction presumes some additional clarification of what is meant by resources. Several approaches to such distinctions are possible. We might, for example, categorize social areas, regions or communities by the social and economic status (SES) of their populations for example since income, status and power are important resources in the ability of persons to gain access to services of all types. Such an approach is likely to be more useful in distinguishing why some persons get services and others don't, however, than it is in distinguishing between areas or communities.

A more useful approach might be to define resources in terms of human service institutions. Thus, in an important sense whether an older person with a health, nutrition, emotional or other problem receives help is dependent to a large degree upon whether an agency, program, service or other human service institution is within a reasonable physical, economic, political or social distance, and thereby accessible. In this way, simple service censuses can go a long way toward helping us to identify communities which are resource rich or poor.

There is also an additional way in which we can classify resource richness or poverty in the context of rural and urban older Americans. We have long understood that as a by-product of the world revolution of urbanization and industrialization human services have assumed responsibility for many problems which were formerly the sole province of the family, kinship group or the other informal mutual aid networks of the community. Unlike organized services such mutual aid is not dependent on the existence of service organizations yet constitutes an important resource for human problem solving. Because such traditional patterns of mutual aid in American life were often tied to other features of rural life, it was once thought to be a distinctly rural helping institution – one completely replaced in urban areas by formally organized services. Shanas, et. al., Rosow, Gans and other social scientists writing during the 1960swent a long way toward dispelling this misconception (Gans, 1963; Rosow, 1962; and Shanas, et. al., 1969). Herbert Gans (1963) found that the West End neighborhood in Boston had a network of mutual

aid equal to that of any rural neighborhood in America. And Ethel Shanas and her associates found similar circumstances not only in the United States but in urban Britain and Denmark also. Well over three fourths of all older persons in these three countries lived within one hour of at least one adult child and called upon children, other family members and significant others when help was needed.

Thus, the question of the problems of the aged in rural areas must ultimately be resolved along three dimensions: the SES of the resident populations, the comprehensiveness of the organized service delivery system, and the mutual aid patterns distinctive to a particular community. Where all three are present one would expect to find very few unmet needs; where all three are absent (as in some urbanizing areas of the third world) one would expect to find appalling conditions of overwhelming human need. Most American communities represent variable combinations of these three patterns in the middle range.

The policy implications of these basic resource patterns for meeting the needs of older people in non-metropolitan America and complex and numerous. Most urban communities today are continuing to respond to these needs, solely or principally with services only. Ultimately the question of SES is an issue of equality and to be resolved in terms of federal income maintenance policy, state and local education policy and anti-discrimination legislation such as the Age Discrimination Act.

The most intriguing possibilities at the present time for innovative work with the aged in rural America appear to lie in the encouragement and development of new or improved mutual aid relationships. This is not because rural areas have anything like a monopoly on kindness, friendship or human decency as some living there may suspect, but rather because the momentum of history is currently swinging away from the distinctly urban service approach on several fronts: The federal government has sought for several years to cut expenditures for services to older people and other groups. OEO, Model Cities and many other urban programs of the Great Society have either disappeared entirely or become morally and political vacuous and professionally uninteresting. The urban crisis, largely discovered by human services interests in the 1960s, is increasingly being expropriated as an issue by those whose primary concerns are public finance and local basic public services. In large measure, Title XX appears to be little more than the same old soup served up in new bowls.

In this context and with the prospect of the first genuinely "small town boy" as President in several generations, it is not unreasonable for the forces of change in aging to be focused increasingly in rural America. It would be sad indeed if these forces focused only on hinge efforts in the first two areas mentioned – status equality and service delivery. Mutual aid is found throughout America. But it is in Rural America where the ideology, willingness and legitimate recognition of this phenomenon exist at present to fully harness this force to meet the needs of older persons.

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