Sociological Practice

Volume 11
Issue 1 *Social Gerontology: The Linkage of Sociological Knowledge and Practice*

Article 7

January 1993

Section: General Policy Issues

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Economic Diversity and Informed Old Age Social Policy

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ABSTRACT

The issue explored here is an example of the interface between social research and social policy in the United States. The aging policy debate concerning the economic status of the elderly has tended to focus upon the disadvantaged; it is informed by a relatively selective view of the financial resources of older persons. The result has been policy that is vulnerable to the market attention given to the advantaged elderly by business as the economic status of the elderly improves. Sociological practitioners whose work focuses upon older Americans are in a unique position to understand this policy problem and to address the needs of the elderly on both ends of the economic spectrum.

Applied sociology, the use of sociology in problem-solving (Clark, 1986), finds fertile soil in the vineyards of gerontology. Applied sociologists, accustomed to examining national datasets that outline macro-level social conditions and social change, can be of immense help to the policy and practice communities in gerontology as they struggle with issues of policy analysis and social impact assessment. The focus of this article is to understand the economic diversity in the changing older population in the United States (Taeuber, 1990). A course of action for sociological practitioners is not being

recommended in this essay, rather, it is a call to understanding in the policy debate encompassing the economic status issue.

Economic Diversity of the Older Population

The economic status of the elderly is in flux, a result of the general upgrading of retirement income during the past half century (Smeeding, 1990). The changes that resulted from post-war economic expansion, the many amendments to the Social Security Act during the 1960s and 1970s, the federal regulation of pensions in the 1970s, and the increase in investment income during the 1980s have placed at jeopardy older stereotypes of the poor and frail elder, at one time the poster person of old age.

This ambiguity has given rise to newer stereotypes of "greedy geezers," who are benefiting from Social Security and other old age entitlements *at the expense* of the younger generations (Otten, 1987). However, the intergenerational equity debate has not eroded public support for income maintenance programs. Polls show that Social Security continues to enjoy strong support in every age group, partly because younger people realize that the recipients are their own parents or grandparents.

Writing over a decade ago, Hudson (1978) argued that the aged have been a favored social welfare constituency in the United States and have done relatively well in the arena of public policy compared with other population groups whose needs can be argued to be equally pressing. Not all agree. Quinn (1987) noted that poverty rates among the elderly can be manipulated, depending upon one's assumptions about how much, if any, in-kind benefits (such as Medicare and senior discounts) count in one's family income. Quinn also pointed out that there are built in assumptions about family size that may advantage or disadvantage older households in the standard poverty formula depending upon the living arrangements of older persons. Kutza (1981), among others, argued that minority older persons and older women have not shared in the gains experienced by other older people, whereas Nelson (1982) suggested that government programs for the aged have simply perpetuated the existence of socioeconomic differences among elderly people that existed prior to old age.

The applied sociologist attempting to assess the impact of changes in the economic status of the elderly on public opinion, public policy, and age-targeted community services would do well to begin by examining the economic diversity within the older population. Such a study was conducted by Longino and Crown (1991), who analyzed the income and net worth of

the population over age 65. Their analysis was based on original tabulations of the 1984 Survey of Income and Program Participation (SIPP), a comparatively new survey produced by the U.S. Bureau of the Census. The SIPP aims to collect the most comprehensive set of income, employment, and asset data on individuals ever attempted on a continuing and nationally-representative basis. Their study reported cross-sectional distributions of income and net worth for older households in 1984.

They found that married couples aged 65-69 had a median income of $20,340, with declining median income for more advanced age categories. The median income of all older married couples was $17,880. Moreover, the median income of nonmarried older persons was about half that of married couples in all age categories. On reflection, this is not particularly surprising since most nonmarried elderly live alone and, consequently, their household size tends to be about half that of married couples.

The study's most striking findings, however, were not the income figures but those for total net worth. The median total net worth of all older married couples was $86,487 in 1984. Average net worth varied from $3,437 in the lowest quintile to $297,442 in the highest. As with income, net worth was highest for the youngest married couples ($92,500), and declined for older cohorts. Also, like income, net worth was substantially lower for nonmarried persons than for married couples. Interestingly, however, the correspondence between income and net worth was not found to be as high as one might expect.

Sources of income varied, of course, between quintiles of net worth, the richest quintile receiving higher proportions from property and business income and the rest receiving the highest proportions of their income from Social Security. Interestingly, earnings contribute about a quarter of the total monthly income to households in each of the wealth groupings.

Longino and Crown (1991) further found that the vast majority of older households, except in the lowest net worth quintile, have asset holdings in their home, their automobile, and in banks. Substantial proportions of households in the upper quintile also have other holdings, especially in stocks and rental property.

Economic Diversity and Old Age Social Policy

Most of the public debate concerning the economic status of the elderly is informed by a relatively limited view of the financial resources of older persons. While there is little doubt that the economic status of older persons

in the United States has improved substantially since the 1970s (Crown, 1989), this view is typically limited to the monetary income of older households—an approach criticized by economists because of the relative transitory nature of monetary income. Further, this view is often based on economic improvements in households below or near the poverty line.

The public perception of the economic status of the elderly has changed dramatically in recent years, from images of abject poverty and pet-food dinners to stereotypes of double-dippers and the pension elite (Kart, et al., 1989). It is becoming clear, however, that the true picture of the vast majority of older persons is somewhere between these two extremes.

Both income and net worth vary substantially within the older population. Age differences within the 65+ population are strongly associated with variations in economic status. The older the household, in general, the lower the aggregate level of both monetary income and net worth, although there are variations associated with marital status (Longino and Crown, 1991).

Schultz may well have pinpointed the truth behind the changing perceptions of the elderly (1983:1):

> Looking at [the] new Census Bureau findings and a number of recent studies, one can begin to see the outlines of a very fundamental change with regard to the economic status of the elderly. From a statistical point of view, *the elderly are beginning to look a lot like the rest of the population;* some very rich, lots with adequate income, lots more with very modest incomes (often near poverty), and a significant minority still destitute. This is very different from the past when most were destitute.

Like a blind person describing the entire elephant from his or her selective tactile data, varying characterizations of the economic status of the elderly are likely to reflect an incomplete (or at best a selective) perspective based on partial information. Those who see the elderly as poor may well be looking at the oldest segment of the older population, and especially older widows, while those who prefer to discuss the rich elderly are more likely to be looking at those who are recently retired and younger.

These economic issues become fodder for a battle between parts of the public and the private sector over elderly clients or customers. In order to understand this battle, it is important to appreciate that aging is in this sense socially constructed. The differing interests of the two sectors cause them to define the subject quite dissimilarly and this dissimilarity creates a difficult problem.

The Public/Private Perspectives

The highly respected applied sociologist of aging, Carroll Estes (1979), has referred to the vast array of programs, bureaucracies, providers, interest groups, and industries that serve the elderly as *The Aging Enterprise.* She brings the economic status of the elderly into a sociological, rather than strictly economic, focus by emphasizing the ways that economic data are interpreted *in the interest of* the aging enterprise. She argues that this social-medical-industrial complex does more to meet the needs of the service system than the needs of the elderly. According to Estes, the needs of older persons are, in fact, defined by the system itself. These needs are made compatible with the organization of the American economy.

Estes' book appears to be increasingly prophetic. The public sector, on the one hand, has tilted in the direction of addressing the needs of those in greatest social and economic need. Being age 65 or older, by itself, no longer necessarily qualifies a person to receive many of the services that were initially designated for all older persons. The private sector, on the other hand, has identified a "mature market" that can afford products and services that make their lives more manageable when faced with the functional limitations associated with aging. Geographic concentrations of the upscale elderly are of particular interest to industry (Longino and Crown, 1990). Thus, two very different images of the elderly shape the way that service needs of the elderly are addressed, while the majority of middle-class older Americans are left somewhere in between.

Kaplan and Longino (1991) describe this situation as a "public-private conundrum." This conundrum is a result, in part, of the increasing awareness of the diversity of the older adult population. Government reports regarding the plight of the elderly gloss over the fact that there is a substantial proportion of older persons who are economically advantaged (Kart, et al., 1989). At the same time, advertisements that depict older persons as affluent impinge upon the negative image of older persons as poor and socially disadvantaged, which helps to shape social policy and to mobilize public resources.

Sociological practitioners who focus their professional attention on older Americans certainly will be among those combating the tendency of social policy to see older people as lacking diversity, especially when this simplified view is motivated primarily by self-serving organizational considerations. There is room for both publicly and privately supported service systems to meet the needs of the elderly.

Conclusions

Gelfand and Barresi (1987) describe a tendency among researchers and policy-makers to view age as a leveler. That is, differences that may have existed earlier in life are thought to level off with age. This bias neglects salient issues that differentiate the aging experience of older individuals. Sociological practitioners, especially those who assess the needs of or serve an older population, must avoid such centrist thinking, which neglects the importance of economic diversity among the elderly. Our grounding in sociology should inform us to think in terms of both central tendency and deviations from the mean on all measures. The question remains, however, as to how the diversity of the elderly population, particularly economic diversity, might be addressed.

Overall, then, a number of public and private sector challenges and opportunities are suggested by the economic diversity of the older population in the United States. At a minimum, business and policy leaders should acknowledge the broad range of diversity in the economic status of the elderly, varying by age, by definition of economic status, and by other characteristics. They should also acknowledge that while there are simultaneously those with very high and very low levels of lifetime accumulations of net worth, some 60 percent of older households' net worths are somewhere in the middle, with averages between $32,091 and $111,682 (in 1984 dollars).

While almost all older households report assets in the form of automobile equity, interest-earning accounts in savings institutions, and some stocks, mutual funds, and bonds for all but the wealthiest and poorest older households, the largest asset holding is found in their home equity. As Schulz suggests, the older population mirrors the nation more generally in being largely middle-class. The challenge, then, is to find ways that these resources can be preserved. Public policy should be aimed at encouraging and protecting pensions and stimulating private savings—especially as the nation enters a period of rapid middle-aging as the baby boom matures into its 50s over the next decade (Cutler, 1991).

Finally, perhaps the best illustration of the need to consider the broad range of the middle-class elderly, along with the poor and the wealthy, involves health care generally and long-term care in particular. The Medicaid system will be more likely to provide adequately for the poor if the middle class elderly have broader options for the financing of their own catastrophic medical care and long-term care. Clearly this suggests the need for consideration of both public and private mechanisms. The major

revamping of the American way of financing health care in general, perhaps the principal policy debate of the mid-1990s, will inevitably provide a framework for long-term care. It is difficult to be explicit about the outcome of this debate, however, because it is not likely to take concrete form until sometime after the 1992 election.

As a society, we have had some success during the past several years in responding to the poverty of older Americans. The task for future years is to respond to the current economic challenges which face elderly households. To do this requires that we must respond, not to outdated or distorted stereotypes, but to the facts of elderly economic status, including the poor, the middle-class, and the wealthy elderly, as we can best discern them. This requires portraying economic status as distributions rather than simply as averages. It also means that in addition to looking at monthly or annual income, we must also conceptualize and measure economic status in terms of assets and wealth —because assets and wealth, along with income, determine the economic behavior of most older individuals and their families.

Recommendations

If old age policy does become more informed and economic diversity is taken more into account, then there will be plenty of room for applied sociologists to work for both the public and private sectors in meeting the needs of older citizens. There will be opportunities such as market research for private industry and service planning for government. Both call for interventionist strategies—they just simply aim at opposite ends of the retirement income and wealth spectrum.

We wish to express our appreciation to Gloria Cabrera and Carol Corum for the technical production of this manuscript. Many of the issues discussed herein were developed with the assistance of a grant from the AARP-Andrus Foundation.

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Health Policy Development: Health Promotion and Illness Prevention Among Older Adults in Illinois*

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ABSTRACT

This paper offers recommendations for health promotion and illness prevention for older adults in Illinois and offers a structure for policy development. It is based on the premise that policy development should consider the experiences of older adults, family members, and health care providers delivering direct services. Personal experiences and expert analyses were examined in the context of strategies to promote health. This example of policy development is discussed in terms of its application to alternative methods of social and health change and identifies roles for the sociological practitioner.

* Funding for this paper came from the Retirement Research Foundation, Baxter Foundation, and the League of Women Voters of Illinois Education Fund.

Introduction

The means by which public health policy for older adults is formulated is often marked by a lack of understanding as to the needs of older adults as well as to the concerns of policymakers and the service delivery system. Meaningful health policy must be an integration of the concerns of older adults, service providers, and policymakers. This paper focuses on policy development for health promotion and illness prevention for the aged based on input from older adults and service providers, and offers a structure for an alternative method of social and health change.

Implementation of this program began with public hearings which gathered testimony on personal experiences from older adults, family caregivers, and other community groups concerned with health care for older adults. This testimony offered themes, or content areas, for briefing papers. Health promotion/disease prevention for older adults was one of the themes identified. Once identified, a health promotion briefing paper was written incorporating:

1) testimony offered through public hearings; 2) a review of national and statewide documents pertaining to illness prevention for older adults; and 3) a statewide survey of actual services available pertaining to health promotion and disease prevention. A briefing paper which offered recommendations for policy development was circulated to health care providers, advocates, and other community leaders, who evaluated and suggested revisions of the recommendations. What follows is a list of goals for health care policy and strategies to meet these goals.

This paper provides an overview of issues associated with health promotion and disease prevention for older adults and a summary of the status of prevention in one state—Illinois. Although the recommendations offered are specific to Illinois, both the procedure and many of the recommendations are applicable to other states. The paper concludes with recommendations for promoting prevention efforts and a discussion of the role of the sociological practitioner in the process of health care policy development. Our goals are to offer and examine recommendations which may help these efforts, thereby resulting in better comprehensive health care policy for older adults within the state; this study may serve as a model for other states as well.

Background

The health and well-being of older adults is not just the result of health care and medical interventions; it is also a consequence of day-to-day efforts in health promotion and disease prevention. It is now widely recognized that

prevention in older adults can be both efficacious and effective in preventing or delaying the onset of many chronic diseases and can contribute significantly to reducing disability associated with chronic illnesses. "From a public health perspective, preventive activities stand out as an important tool. If it is possible to prevent the development of debilitating chronic disease, to delay its onset, or to reduce the disability associated with it, then such activities could go far toward meeting at least some of the challenges associated with an aging population" (Kaplan and Haan, 1989:28).

Advancing age in the United States is associated with the onset and progression of chronic illness and disability. Prevention plays a major role in the treatment of many of these diseases and chronic conditions. For example:

- 80 to 90 percent of all reported deaths from influenza occur among persons aged 65 and older. Only 20 to 30 percent of older adults receive flu shots each year (Buchner, et al., 1989).
- Nearly 26,000 persons aged 65 and older died in 1987 as a result of unintentional injuries (NCHS, 1989).
- Estimates of the percent of elderly aged 65 and older with drinking problems are 10 percent or greater, with 8 percent of these being classified as problem drinkers (Atkinson, 1984). Alcohol use has been associated with cognitive deterioration and a number of chronic illnesses, including liver disease, cardiovascular disease, hypertension, and stroke. Nationally, alcohol dependent individuals account for about 20 percent of nursing home residents (Atkinson, 1984).
- According to the National Council on Patient Information and Education, at least 60,000 [older] Americans lost their lives needlessly in 1986 alone as a result of not taking prescription medication properly.
- Diet is a major factor in late onset diabetes and plays a role in some forms of cancer, stroke, and osteoporosis, as well as other diseases (Woolf, et al., 1990a).
- The U.S. Surgeon-General has said that as much as half of all U.S. mortality may be the result of lifestyle and behavioral factors (Surgeon General's Workshop, 1988).

Given the impact of lifestyle on chronic illness and disability in older adults, it seems difficult to understand why more attention has not been directed to prevention in this group.

Cost Benefits

It has been argued that prevention programs for older adults are an inappropriate use of health care resources, in that any program designed to prevent

illness and reduce mortality and disability will show diminishing returns with advancing age and frailty of the target group. Others claim that it is more appropriate to devote these resources to infant and child programs than to older adults, and that medical care limits should be set for an aging population (Callahan, 1987).

Cost effectiveness and cost benefits of prevention services for older adults need to be considered in more than dollars saved and years of life extended or even the percentage of individuals who have prevented specific illnesses. The full impact of health promotion and prevention for older adults must include indications of the degree of disability prevented, improved quality of life, and the length of delay in which costly health care services such as institutionalization have been diverted. In addition, the costs and consequences of inappropriate health practices should be examined in the context of the family and the total community. For example, the older problem drinker on the road is as potentially threatening as younger motorists who are intoxicated.

Cost benefits have been documented for prevention programs such as immunizations for older adults in the community as well as in nursing homes (Sims, 1989). Other prevention strategies, such as walking exercise programs, have low associated costs with significant health gains. Maximizing individual and self-help initiatives whenever possible and designing programs that utilize existing resources are keys to cost effective preventive services.

Targeting

It is often difficult to identify those older adults in the community who would be the most appropriate group for whom to target health promotion. With an estimated elderly population (aged 65 years and older) in Illinois close to 1.5 million, health promotion/illness prevention cannot be all things to all people. However, contact with the most frail of the older population most frequently occurs in the health care system (i.e., during hospitalizations, within the community care program, and during physician's office visits). It seems logical and cost effective, given that a system already exists which identifies these individuals, that prevention efforts should utilize this method of contact with the elderly.

Another method of targeting prevention efforts for older adults is to consider resource deficiencies for specific groups such as rural elderly and ethnic groups. "Older rural people, by almost all economic, health, and social indicators, are poorer, less healthy, live in poorer stock [housing], have

fewer options in personal transportation and less availability of transit services, and have significantly more limited access to health professionals as well as community based long-term care programs and services than do their suburban and urban counterparts" (Howard and Bane, 4 March 1991:14). This, then, would seem to be an appropriate population to target.

Prevention efforts should also be targeted to older persons who are relatively healthy and would take full advantage of health promotion initiatives. Prevention efforts have been criticized for their focus on the majority population of elderly and on messages and interventions geared toward the advantaged socioeconomic groups. Although there is a need to continue efforts for the majority of older adults, it is critical to target culturally sensitive prevention efforts at minorities, because of their large percentage of "at risk" older adults. The key to successful targeting is that the prevention strategies and programs recognize the limitations and possible accomplishments of the intended audience.

Prevention Responsibility

As critical as health promotion and illness prevention are to the health and well being of older adults, in most cases the individual has the right and responsibility to decide whether to engage or not to engage in these activities. Immunizations for older adults, for example, are not required by law in Illinois. Informed consent is required and patients are given information on the benefits and consequences of immunizations. However, when the decision of the individual to forego appropriate health practices impinges on the rights and safety of others in the community, the rights of the community must take precedence. Thus, immunizations may be required for persons entering a nursing home or other community facilities in which the health of others may be affected. Still, the primary responsibility for health promotion and illness prevention lies with the individuals themselves.

Health professionals are also responsible for health promotion and disease prevention. Persons aged 65 to 74 consult with a doctor an average of 8.2 times each year while those aged 75 and older see or talk to doctors an average of 9.9 times per year (NCHS, 1986). The National Health Interview Survey reported that 87 percent of persons aged 65 years and older had access to health care in the past year (NCHS, 1986). This suggests that the clinic setting would be an ideal location for dissemination of illness prevention information and health education. Despite the potential impact of the clinic setting, however, prevention plays an insignificant role in the education of most physicians. In a survey of 90 medical schools,

Moser, et al. (1985) found that students receive an average of only 18 hours of instruction in hypertension management over the entire course of their education, even though it is the most common chronic disease in America. It would seem, then, that the role of the health care system in health promotion and illness prevention should be increased.

The government must also play a role in providing opportunities for the individual to take full advantage of resources to promote health and prevent disease. The sociological practitioner can provide a basis for understanding health care decisions and the impact of these decisions on society as a whole. The role of health education is to provide information about the risks and benefits of a healthy lifestyle. Based on this information, it is up to the individual to decide whether or not to adopt these activities. It is, however, the right of older adults to have access to health promotion services. The division of responsibility is best summarized by Green and Kreuter (1990:329): "The practicalities of health promotion planning require that the optimum mix of responsibility to be assumed by those involved—individuals, families, professionals, private or governmental organizations, local or national agencies—must be worked out on a case-by-case basis. It is essential that those directly affected have a voice in negotiating this division of responsibility."

Basis for Recommendations

The following summary of the status of illness prevention and health promotion for older adults is based on three sources of information: testimony offered during the ElderHealth public hearings sponsored by the Illinois League of Women Voters; a review of national and statewide documents pertaining to illness prevention for older adults; and a statewide survey of health promotion and disease prevention services available in the state. The statewide survey was distributed to a representative sample of local health departments and to all Area Agencies on Aging. This summary is followed by a statement of concerns and problems regarding illness prevention for older adults in Illinois and a list of recommendations to address these problems.

ElderHealth Public Hearings

Six public hearings were held in rural, urban, and suburban areas across the state as part of the ElderHealth project. The purpose of the public hearings

was to provide a public forum in which those most directly involved with health care issues for older adults could express their concerns and comments on the health needs of the aged. Older adults, representatives of agencies concerned with the health and well-being of older adults, government officials, and concerned individuals were invited to provide written and/or oral testimony during these hearings. A summary of prevention issues raised during the hearings follows.

Unlike other health issues discussed during the public hearings, relatively little direct testimony was offered concerning the need for assistance in matters of prevention services and health promotion. The reason for this is that prevention is traditionally viewed very differently by health professionals and the public. Physicians are likely to hold a biomedical view of prevention and offer technological interventions, such as inoculations and medical screening, while public health professionals are likely to view prevention in terms of environmental risks and behavioral risk factors. The older adult may not even tend to view health promotion and disease prevention services as part of health care services. While most individuals understand the relationship between health risk behaviors and chronic illness, they may not request assistance to change inappropriate health practices. Other individuals typically see treatment rather than prevention for behavioral risk factors as the appropriate response from the health care system. For example, testimony was provided concerning the need for treatment of older adults with alcohol related problems. However, there was no testimony offered concerning how to prevent alcohol abuse prior to it becoming a health problem. A written synopsis from the hearings recognized only the need for alcohol and drug treatment.

> The abuse of alcohol and other drugs only exacerbates an older adult's medical problems and ensuing costs. By offering senior outreach services which can help them obtain needed chemical dependency treatment, there are health and life quality gains which can be made by the individual, as well as a financial gain by those who must pay the medical costs created by alcoholism and drug dependence. Unfortunately, sometimes professionals are unaware of the problems of substance abuse of older Americans.

There were a few individuals providing testimony at the public hearing who did recognize the utility and the need for preventive services. For example, written testimony from the Older Women's League stated that:

> Some [insurance] policies still do not cover preventive tests such as a yearly PAP test. If health insurance companies want to reduce costs by preventing illness, they need to invest in wellness and preventive coverage. Statistics show that women access health care more often than men, and many problems women encounter, such as osteoporosis, are related to aging. Research has shown some of the effects of these problems can be decreased with proper early detection and treatment, but most insurance will not pay for a physician's most important diagnostic tool—a complete physical.

Testimony also referred to the difficulties minority elderly have in accessing services, specifically those services provided under the Older Americans Act. Communication and geographical barriers were cited as the most evident. Difficulties in communication between the provider and the minority client in marketing services and in explaining health promotion avenues, as well as between the client and the provider due to cultural and emotional differences, were reasons for these access problems.

Concern over prescription regimens was also mentioned. Elders are often not compliant for a host of rational reasons, including: hearing difficulties when instructed on medication use; vision difficulties when reading printed instructions; and the lack of standardization of medication color and shape.

Recommendations concerning prevention for older adults were occasionally offered, including developing a program of regular physical activity and good nutrition; avoiding risk behaviors (e.g., overeating, smoking); maintaining an active mind; and maintaining and developing a spiritual awareness.

Prevention Literature

Probably one of the best known documents pertaining to health objectives for older adults is *Healthy People 2000: National Health Promotion Disease Prevention Objectives* (Healthy People 2000, 1991). In this work, national goals have been offered concerning the health and functional status of older adults in the U.S. which include a number of prevention objectives. The U.S. Preventive Services Task Force (USPSTF 1989) has provided a summary of prevention strategies specifically for older adults (Woolf, et. al. 1990a, 1990b). The recommendations of the USPSTF were intended only for clinical settings, however, and do not apply to preventive interventions in other community settings. Another resource which served as a basis for the recommendations that follow was the Institute of Medicine (IOM) report on health promotion and disease prevention in later

life (1990). Information derived from these national resource documents (USPSTF report, IOM report, Healthy People 2000) were then examined in the context of health care and health promotion strategies offered by the Illinois health care system as presented in *The Road to Better Health for All of Illinois* (Roadmap Implementation Task Force, 1990).

Recommendations from other sources were reviewed for specific health practices and disease prevention methods for older adults. These included: nutrition policies and implementation strategies (Marion and Gilbride, 1990), designing medication instructions to promote proper medication management (Morrow, et al., 1988), and the *Surgeon General's Workshop Proceedings on Health Promotion and Aging* (1988) pertaining to alcohol, physical fitness and exercise, injury prevention, medications, nutrition, preventive health services, and smoking cessation. Enhancement of the health status of the older citizens of Illinois through prevention is also a major concern of the public health system. Recommendations from the Roadmap Implementation Task Force (1990) were considered.

Illinois Prevention Survey

The list of preventive health services investigated in the following pages is not exhaustive, but it does delineate major service areas of concern that are reflected in the survey results (discussed below), literature, and/or taken from the testimony.

These areas of service have been divided into four categories: 1) modification of behavioral risk factors; 2) screening tests; 3) counseling and health education; and 4) immunizations.

A survey was distributed to the thirteen Illinois Area Agencies on Aging (AAoA) and to two health departments in each of the eight regions defined by the Illinois Department of Public Health (IDPH). The survey's purpose was to locate agencies that provide preventive health services, to enumerate the specific services provided or funded, and to list barriers associated with care delivery. Because of time constraints, a comprehensive study of the services provided was not an option; but with the plethora of information already written, facts gathered during the survey process, and working knowledge of the public health industry, a general idea of existing services, barriers or lack of services, and general practice in delivery of services can be offered. The services listed do not include the private physician population, although the paper alludes to problems associated with care offered at that level.

Modification of Behavioral Risk Factors

These risk factors include tobacco use, alcohol consumption, drug use, lack of physical activity, and inadequate nutrition. Available services for reducing tobacco use are basic smoking cessation classes. These are offered sporadically through a variety of different agencies: AAOA, local health departments (LHDS), American Association of Retired Persons (AARP), local hospitals, and continuing education programs (CEPs), in addition to other community organizations. One difficulty in determining the effectiveness of these classes is that most programs are not tailored for the older individual. Even when funding is designated specifically for the senior population, the provider is rarely trained to tailor the program to this group. Also, the necessary follow-up by personal physicians is not usually available to seniors (or any audience) because many physicians do not include a discussion of lifestyle changes in their normal appointments. Physicians rarely counsel older patients to quit smoking. CEPs offer classes for a minimal fee and offer discounts for the senior population; but again, classes are not tailored for older adults. Fees charged, minimal continued follow-up service, and lack of continued physician emphasis on modification of health habits not only limit the clientele that use these programs, but deter permanent change. Additionally, in marketing this type of service, LHDs and other agencies often focus on pregnant women who smoke. Although this is a necessary target, it may keep the older population from using this service. New formats specifically for the older population have been developed, but have yet to be implemented in the community on a regular basis.

Alcohol consumption and drug use are sometimes dealt with at the community level, but usually only on a referral basis. Referral is given only when behavior has reached a point that requires a program for treatment or even institutionalization. Most agencies and even private physicians offer a referral system; however, the system is not standardized. The Illinois Department of Alcohol and Substance Abuse refers agencies and individuals to programs for treatment and further prevention.

Although physical activities may not be the focus of many health related agencies, the AARP offers many programs, specifically designed for the elderly, on diet and exercise through local community units or chapters. Existing formal and informal exercise groups (e.g., mall walking exercise groups) are relatively scarce and not well-known in the communities in which they are found. Private membership to facilities is another option, but it can be costly and not realistic for the older individual when they are designed and marketed for younger, unimpaired individuals. The exception occurs when a physical fitness or rehabilitation program is prescribed by a

physician and coordinated with a local hospital, but this is generally only initiated as a result of serious illness. Television also offers low cost opportunities in some areas: some exercise programs are specifically designed for the older or homebound adult, but these require motivation on the part of the individual and need to be incorporated into other areas of a healthy lifestyle.

Inadequate nutrition is often a problem for the older adult, especially those living alone or on limited incomes. The survey revealed an abundance of available services: the Community Care Program offers assistance in nutritional meal preparation; AAOAs coordinate congregate meals, home delivered meals, and nutritional education; LHDs offer education on eating habits and weight loss practices; and local churches and lodges offer congregate meals and meals on wheels.

Screening Tests

Screening tests include both physical testing, such as height, weight, blood pressure, vision, hearing, and clinical breast exams as well as lab and procedural testing, which include cholesterol, mammogram (now covered under Medicaid) , fecal occult blood, tuberculin skin test, colorectal, diabetes, Papanicolaou smear, osteoporosis, and digital rectal exams. The most commonly offered screening tests are those that are physical in nature. This is mainly due to cost and the fact that providers need not be licensed. Testing most commonly offered are cholesterol and Pap smears, both of which are given through LHDS. AAOAs offer minimal screening, which may include diabetes and cholesterol testing, and some offer wellness programs which include most physical testing.

Counseling and Health Education

Counseling and health education encompass a wide variety of subjects. Of major concern for older adults are counseling on medication use and misuse, basic health education and promotion (e.g., self breast examination), and injury prevention (e.g., home safety, home safety assessment, safety belt usage, and use of smoke detectors).

Medication misuse is a result of many factors, including an inability to pay for needed prescriptions. The coordinator for Health Advocacy Services (HAS) of the AARP indicated that many inappropriate uses of medication are a result of economics. And all too often elderly swap medications they are no longer using, or take only half of the prescribed dosage to extend and minimize usage. The Pharmaceutical Assistance Program (PAP) helps eliminate misuse of necessary medications by assisting with

payments for cardiovascular heart medicines, arthritis medicines, and insulin. The PAP, however, is only offered to Circuit Breaker claimants. Other medical programs exist but are not statewide and are not normally covered by financial assistance programs. Many gaps therefore, appear in this area.

Basic health education is offered by many agencies: AARP has health promotion information available through health fairs or by contacting their local offices. LHDs have health education units offering health seminars on particular topics to the community. Some LHDs also offer adult health clinics that incorporate education on lifestyle and self breast examinations, and provide relevant literature. The benefits of health promotion literature, however, presuppose the ability to read and comprehend.

Risk reduction of unintentional injury by education on injury prevention (e.g., home safety education, home safety assessment, safety belt usage, and use of smoke detectors) is offered by the Community Care Program through the Illinois Department on Aging (IDA), since these programs are designed for home and general safety education. (Actual classes are provided by the Case Coordination Units, which are community based agencies). Local AAOAs offer home safety education and driver education, as well as other educational seminars.

Immunizations

Three types of immunizations to which every senior should have ready access are tetanus-diphtheria booster (Td) influenza vaccine, and the pneumococcal vaccine. AARP offers free immunizations when funds are available, and LHDs offer some free immunizations, specifically tetanus-diphtheria and influenza. However, these are not used to their full extent by seniors because they may either be unaware of the services or they may lack access to them. Lack of perceived utility of these immunizations may also be a problem, which results in less than full compliance. AAOAs offer funding for immunizations in some areas of Illinois, while Medicare covers pneumococcal but not tetanus-diphtheria and influenza.

Concerns and Problem Areas

The following summary is a synthesis of the ElderHealth hearings, the literature reviewed, and the survey discussed above. While a considerable number of services are offered to the older adult, there remain a significant proportion and number of older adults who are engaging in health risk

behaviors and inappropriate health practices. Without additional efforts in primary prevention, we can expect to see these numbers increase considerably in the future. Hickman (1990) argued that community level health promotion program interventions must incorporate sociological concepts when adapting primary prevention interventions to the community. The AAOAs commented that numerous services are available, but that there are many obstacles in receiving them. Those obstacles most prevalent are lack of finances, transportation, or actual knowledge that services exist. Also, no standardization of services exists between agencies and/or areas. The AAOAs as a provider and funder of services have difficulty in gaining enough human resources, especially in rural areas. LHDs also have inadequate funds and tend to prioritize programs for the younger age groups.

Illinois currently has no method of determining the extent and focus of prevention efforts from region to region throughout the state or the success of these programs in targeting and treating older adults. Surveillance of behavioral risk factors in older adults in Illinois is minimal. IDPH is currently accumulating information on the reported health practices of adults residing in the community via the Behavioral Risk Factor Survey. While the Behavioral Risk Factor Survey can provide information about which older adults are at risk due to health risk behaviors, it will not tell us why the problem exists. It is unlikely that the survey can be used to evaluate the success of a specific program or to inform us as to the type and level of preventive services available in a specific area.

The LHD and AAOA believe that services are available, but a percentage of individuals do not have access to them or lack services in appropriate areas at the time of need. Many of the gaps in services could conceptually be covered by a mix of LHDs and township or other municipal programs. However, the current level of service is varied and responsiveness is different for each area and type of government. Lack of LHDs in some counties also complicates service provision. There is evidence that low participation of minorities may more likely reflect cultural and ethnic, rather than racial differences. For example, although safe and effective vaccines to prevent pneumonia and influenza are available, minorities and other identifiable at risk older adults (e.g., those living alone) are underutilizing these immunizations. Although there are multiple reasons for older minority underutilization of health care services, utilization is often limited by inadequate marketing. Providers often target these populations, as mandated by the Older Americans Act, but have had limited success. Many cultures and handicaps need to be addressed when considering marketing strategies and health education to senior populations. Greater participation

in health promotion program activities by divergent ethnic groups is more than a matter of cultural sensitivity. The considerable sociological research on understanding ethnic norms, values, and belief systems can be employed to overcome low rates of participation by these ethnic groups (American Association of Retired Persons, 1990).

Access to transportation presents difficulties for frail older adults due to design barriers. Although "medicars" and other sources of transportation are available, the number and service areas of these vehicles are limited. Transportation problems due to difficulties in "getting through" on the telephone to arrange for transportation was also expressed as a concern in the public hearings.

Prevention services are more limited in rural areas. LHDs in rural areas were much more likely to mention limited prevention resources than LHDs in urban areas. Rural areas have hardships in delivering services because of low population in large geographical areas, and loss of physician population, as well as hospital closures. Rural areas lack the resources more readily available in a metropolitan area because they are affected by economics and population and thus have spatial inequalities (Luloff, 1990). Rural communities would like to open congregate meals and nutrition sites and also offer home delivered meals, but the human resources are not available. In this type of setting, health must be seen as a social rather than a medical problem.

Rural areas also have minimal transportation services available. The provision of preventive services, however, is directly linked to accessible transportation. The importance of access to adequate transportation was examined by the National Association for Counties, which concluded: "Even the best designed elderly housing, health care or supportive services would prove ineffective without the means to make them accessible." (Markwood, 4 March 1991:10).

Larger metropolitan areas have a greater foundation for community-based services which are provided by Community Care Programs (CCP). CCPs offer in-home and community-based services to eligible seniors to prevent or delay premature institutionalization. Although these types of services are also offered in rural areas, the services vary greatly and are not available everywhere nor in sufficient quantities.

Many older adults do see a physician on a regular basis, but relatively few receive health promotion counseling and education from their personal physician (Woolf, et al., 1990a). Findings from the National Health Interview Survey (NCHS, 1986) report that 87 percent of those aged 65 years and older have a particular clinic, health center, doctor's office, or other place where they usually go when they are sick or need advice about

their health. Physicians, however, are less likely to provide health education counseling to their older patients. This is due, in part, to a lack of confidence in addressing such issues with older adults.

Recommendations

Rather than merely repeating prevention recommendations from existing resources, our intention was to offer suggestions which consider recommendations from the three sources of information reviewed (public hearings, prevention literature, and the statewide survey of health promotion and diseases prevention) and apply them to specific needs and resources within the state. The decision to recommend a specific service or activity also had to meet all of the following four criteria:

1. It should be demonstrated that the health risk behaviors impact on the health and well-being of the older adult and the public.
2. The incidence and prevalence of the behavior should suggest that a significant proportion of the older community is at risk.
3. There should be evidence that it is possible to change the level of risk in the older population and that changing the risk factor has meaningful positive health consequences to the individual and the community.
4. The recommendation should be cost beneficial.

In addition to these criteria, recommendations should be evaluated in terms of whether they improve quality of life, as well as prevent or delay the disability associated with chronic illnesses. The success of a program should not be measured by the proportion of older individuals who have specific diagnoses, but rather by the degree to which these individuals can maintain independence in performing daily activities. Estimations of costs for the goals and recommendations offered below are not provided because many of the costs can be absorbed through reassignment of already existing resources. Minimal cost was the intention when developing these goals. Those with potentially higher cost were included due to their importance.

GOAL 1: A coordinated cohesive delivery system of a standardized array of health promotion and illness preventive services should be available.

RECOMMENDATION A: All state programs dealing with health promotion and disease prevention should be the responsibility of one overseeing agency (Illinois Department of Public Health).

RECOMMENDATION B: All senior centers should have a minimum standardized prevention program which includes modification of behavioral risk factors, screening tests, counseling and health education, and immunizations. Senior centers need structure, programs, and a measure of professionalism by staff members.

GOAL 2: Senior understanding and physician, pharmacist, and other health professionals support, and emphasis on preventive services and health education activities should be increased.

RECOMMENDATION A: All health professionals should improve interaction with older adults to encourage healthy lifestyles and preventive services and offer appropriate referrals for these services.

RECOMMENDATION B: Medications must be evaluated carefully to prevent misuse, abuse, or complications.

RECOMMENDATION C: Seniors must be educated as to the importance of health behavior change, health risks, and prevention strategies at their stage in life.

RECOMMENDATION D: When educating and distributing literature, those who have hearing or vision difficulties and those who are non-English speaking or illiterate, should be appropriately targeted.

GOAL 3: A system to monitor the extent of prevention activities for older adults offered through various programs and the success of these programs should be developed.

RECOMMENDATION A: A data base of behavioral risk factor patterns and health risk should be established for all of Illinois using the IDPH Behavioral Risk Factor Survey, demographics, and morbidity information.

RECOMMENDATION B: Patterns of health promotion and illness prevention service use must be determined.

RECOMMENDATION C: Programs should be modified according to data base and current service use assessment.

GOAL 4: Immunizations (pneumococcal, influenza, and Td) need to be available and appropriately given to all seniors.

RECOMMENDATION A: Medicare should be expanded to include TD and influenza vaccine reimbursement.

RECOMMENDATION B: Immunizations should be offered automatically upon hospital discharge of elderly patients.

RECOMMENDATION C: Local public health programs should be encouraged to extend the free immunizations which are offered to children to the senior population.

RECOMMENDATION D: Home health agencies should provide immunizations for all patients or clients.

RECOMMENDATION E: Immunizations of all nursing home residents should be encouraged.

GOAL 5: Remove transportation as a barrier to preventive services.

RECOMMENDATION A: All preventive programs should consider access to transportation as part of their program.

GOAL 6: Reduce the number of unintentional injuries in the senior population.

RECOMMENDATION A: Safety at home should be improved.

RECOMMENDATION B: Automobile safety should be improved. Physicians should be encouraged to report older patients whose medical status may impair driving ability. Safety belt public service education should be tailored to older adults.

GOAL 7: Special programs for high risk and minority senior populations should be available.

RECOMMENDATION A: Existing case management systems (e.g., hospital discharge planners, community care case managers) should be encouraged to assist seniors unable to obtain services or unable to change lifestyle on their own.

RECOMMENDATION B: Improved usage of preventive health services by minority older adults should be encouraged.

GOAL 8: Insure that recommendations in this paper are implemented.

RECOMMENDATION A: A state agency should be assigned the responsibility to review and insure proper implementation of the previously mentioned recommendations.

Conclusions

This briefing paper is an example of public health policy as it developed from the older individual and the community to those who implement specific policy recommendations. Although it is based on the Illinois experience, the means by which recommendations were generated and evaluated may serve as a guide for other communities to enact public policy.

Public hearings are frequently used as a means to generate an understanding of the concerns individuals and community agencies have pertaining to health service delivery. Although public health policy is guided by the medical profession and national health standards (Healthy People 2000, 1991), it also must acknowledge the social context of health care and service delivery. Hickman (1990) noted that setting health in a social rather than a medical context requires input from individuals, families, organizations, and health care service agencies within the community. Public hearings provide a method for these community groups to provide input. Community input through public hearings was useful for generating issues or themes which served as a foundation for identifying the needs of the community. However, public hearings alone are not sufficient for appropriate health care policy development. Once recommendations are developed, agencies and health care providers should assess the practicality of the product.

At least three areas in which sociological practitioners can contribute to this process of health care policy development have been identified. First, by translating and analyzing the health concerns expressed by the community, the sociological practitioner can provide insight into the health care needs of the community. Identification of needed health promotion and education services for older persons is an ongoing process in which health priorities will change as new cohorts enter the aged population. Second, development of public health care policy from community input to legislative action and implementation can be examined and enhanced by sociological concepts. The practitioner will prove invaluable by offering insights into the consequences of health policy recommendations prior to implementation. Finally, sociological practitioners play a valuable role in educating all those involved with promoting the health of older adults. Older individuals need to be informed through health education programs stressing the importance of illness prevention and health promotion activities. The practitioner also plays a pivotal role in developing programs to educate health professionals on the utility of health education and health promotion for older adults.

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Everyday Lives of the Elderly: A Dimensional Analysis*

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ABSTRACT

Considerable dissension surrounds the number and composition of the domains comprising the daily lives of the elderly. The present study employs an array of biological, economic, political, social, and psychological data obtained from a house-to-house survey of elderly citizens to derive a mapping of dimensionality. Factor analysis of the data isolated eight domains: Poor Health, Disengagement, Self-Sufficiency, Female Aging, Meaningful Employment, Political Faith, Self-Starting, and Stoicism. External validation supported the factor solution and highlighted the impact of dietary and economic deficits on the problems of the aged.

Considerable discussion in gerontological circles has concerned the dimensions of mature citizens' lives. In the present study, this issue is addressed inductively and quantitatively by a factor analysis of an array of biological, economic, political, social, and psychological variables. The core domains of elderly citizens' daily existence and the constitutive facets of these domains are delineated.

* We wish to thank Robert Maiden and Karen Porter for their helpful comments on earlier drafts of the article.

The study follows what Rose (1989:xi) has called an "underall" orientation toward public policy. Issues concerning the elderly are examined from the viewpoint of common citizens, not from *a priori* assumptions or mathematical models. From our findings, theorists and practitioners may focus more efficiently on the key domains of daily life and extract the specific questions that must be asked in order to measure these dimensions and formulate appropriate policies.

Dimensional Debate

The study focuses on the central features of the everyday lives of the elderly. These features might be regarded as "life domains" or "dimensions of daily living," i.e., the key factors that structure one's everyday behavior and orientation toward the larger world. The analysis aims to empirically identify a set of salient dimensions that comprise the "life spaces" of the elderly.

A review of previous theory and research on the dimensions of the elderly's daily lives suggests a number of factors that may be central. A collection of essays published three decades ago, *Handbook of Social Gerontology* (Tibbitts, 1960), included such domains as health, income security, status/role, work-life patterns, retirement, leisure activities, family, and religion. In the subsequent literature, one finds similar modal dimensions: health, orientations toward others, social life, participation in organizations, economic/social resources, leisure activities, personal care, life satisfaction, self-esteem, psychological orientations, religion, basic needs, politics, and relationship to organizations providing services (Hoffman, 1970; Fisseni, 1976; Byerts et al., 1978; Hendricks and Hendricks, 1979; George and Dearon, 1980; Berghorn et al., 1981; Altergott, 1988).

These domains have been considered important for many reasons. Lawton and colleagues (1982) stressed the interactions between individuals' behavior and the environment, which is composed of a number of external "life domain" factors like those noted above. A similar collection of essays (Hareven and Adams, 1982) emphasized that the life course of an individual—and changes therein—is part of a complex process of interactions among several dimensions of daily life, which have been listed in the literature.

However, our understanding of the dimensions comprising the daily lives of the elderly is limited, incomplete, and insufficiently verified by empirical analysis. To that extent, appropriate policy formation becomes

problematic. As Borgatta and Montgomery (1987:25) note, "Resources are directed toward the creation of programs to ensure the well-being of the elderly . . . but minimal basic developmental work has been done on the conceptualization and measurement of well-being." A number of domains appear to constitute the key components of elderly well-being (Wan, 1985), including economic status (Usui et al., 1985), involvement in institutions such as the church (Koenig et al., 1988), place of residence (Liang and Warfel, 1983), and a variety of objective life conditions (Okun and Stock, 1987). The comparative importance of these facets of existence, however, is unclear.

Thus, a number of specific questions arise. Exactly how many essential dimensions of elderly life are there? From the listings above, can we isolate a more parsimonious set of dimensions? What are the key items of each dimension? Might some of the "dimensions" listed above, in fact, be subcategorizes of other, broader dimensions? What interdisciplinary linkages (e.g., between biology and social life) can be found within dimensions, and between dimensions and other phenomena? While disciplinarity may have a place in academe, life is experienced quite interdisciplinarily. As the Committee on an Aging Society (1988:3) put it, "One must take into account concepts from and the knowledge bases of diverse fields." The present study aims at providing (1) a summary empirical account of these dimensions, (2) an external validation of the dimensions by means of correlations with other variables, and (3) some policy implications flowing therefrom.

Methodology

In the summer of 1987, a team of trained interviewers went into the field in Allegany County, New York, to survey residents 60 years of age and older in their homes. A proportionate stratified random sample was used to select towns in which interviews would be held. The towns were stratified on the basis of both population size and geographic location (northern versus southern half of the county) to ensure that respondents would be selected from these different strata in representative numbers.

Within each town thus selected, names of potential respondents were obtained from the Allegany County Office for the Aging. The names were derived from lists of residents who had (1) contacted the office concerning services, (2) used county programs for the elderly, or (3) otherwise come to the attention of the office. While this population was not a perfect one from

which to choose, the aggregated listings gave potential access to a large proportion (65 percent) of the county's elderly population. Further, the demographic breakdown of the respondents was similar to that derived from statistics in the 1980 census of the county. There were no evident biases. Thus, we were reasonably confident that the sample adequately represented the county's elderly population.

The interviewers made initial contact with the potential respondents by telephone or home visit. Up to four calls were made if necessary. When contact could not be made, the interviewer proceeded to the next name on the list. If the potential respondent had no telephone, the interviewer proceeded directly to the person's home and tried to make contact. The response rate for completed questionnaires was 72 percent, yielding a final sample size of 358.

The survey instrument was a modified form of the Older Americans' Status and Needs Assessment Questionnaire (Brukhart and Lewis, 1975). Additional questions were then piggybacked onto this questionnaire. Among the addenda were standard measures of personality (e.g., locus of control, openness, extraversion, neuroticism) and political orientation and behavior (trust, interest, efficacy, participation). The instrument assessed the needs of individuals in a variety of areas. The additional items were included to tap the domains suggested above and provide a more interdisciplinary scope to the analysis. The final questionnaire (available on request) thus included a wide battery of metrics in order to more completely map out the everyday lives of the elderly.

Socioeconomic "background" characteristics (e.g., sex, income) were deliberately included in the set of variables to be dimensionalized. These variables, it was thought, constitute facets of daily life in their own right and are experienced as such. It seemed inappropriate to assume that these variables "explain" the various dimensions. They could therefore be examined more usefully as dimensions themselves or as constituent parts of dimensions. As a preliminary means of data-reduction, we constructed a number of summative scales for highly specific and related variables. For example, a Physical Problems Index was formed by adding responses to questions measuring deficits in eyesight, hearing, and other physical capacities.

Findings

We employed principal components analysis to estimate the exact number of dimensions. Out of the total array of variables that were entered into

the analysis, some 48 variables fell into eight comprehensible dimensions with eigenvalues greater than one. Varimax rotation was then employed to obtain uncorrelated factors appropriate for the exploratory nature of our research (Harman, 1976; Kim and Mueller, 1978b)[1]

All of the factors had at least three variables, which suggests their stability and validity (see Table 1). The two highest loadings on any factor usually provide the clue to its interpretation. For the first and strongest factor, the two highest loadings fell on the summative scales which measured physical problems, i.e., physical infirmities (sight, hearing, etc.) and deficits in activities of daily living (dressing, bathing, etc.). Two other variables, namely days of restricted activity and tiring easily, also appear constitutive of a physical capacity dimension. This Factor 1 might be labeled "Poor Health." Associated with these physical capacity variables are those variables reflecting psychological health and relative satisfaction with life. Concerns about physical health not only seem to represent the major dimension of everyday life, they are also bound up with psychological states. Also associated with Factor 1 is a variable indicating inadequate social contacts. In short, overall satisfaction with daily life among the elderly seems largely dominated by health condition.

Factor 2 we call "Disengagement." We are aware that use of this concept reflects a theoretical position in poor repute among gerontologists. Here, however, it shows up as the second strongest factor. The variables reflect *nonparticipation* in political activities and social organizations, as well as a minimal stock of essential resources, such as low education and income. Note that the specifically social variables (e.g., club membership) do not necessarily reflect the actual amount of social contact, which was constitutive of the Poor Health factor. These variables tap objective organizational connectedness to the community, rather than social isolation or lack of "bi-lateral" contacts with other citizens. The fact that our measures for a narrow material resource base fall into this "withdrawal" factor is illuminating. It suggests that *organizational* disengagement is a function of socioeconomic structure (Schattschneider, 1960). Note, of course, that health variables do not load on this factor. The implication is that a low degree of group engagement derives more from one's position in the socioeconomic structure than from one's physical condition. Shyness loads on this factor as well. This "psychological withdrawal," in turn, may hinder the "pyramiding" of intellectual and economic resources available through involvement in educational and occupational institutions.

Factor 3 represents "Self-Sufficiency." Items loading most heavily on this dimension suggest individualism (questions from an index tapping

TABLE 1
DIMENSIONS OF LIFE AMONG THE ELDERLY

	1	2	3	4	5	6	7	8
Physical infirmities*	.691							
Deficits in activities of daily life*	.651							
Feeling useless	.632							
Non-enjoyment of life	.628							
Days of restricted activity	.538							
Hopelessness	.531							
Dissatisfaction with life in general	.489							
Problem with spare time	.471							
Inadequate social contacts	.429							
Sense of worthlessness	.429							
Tire easily	.414							
Low political involvement in community		.737						
Few contacts with bureaucracies		.651						
Low education level		.604						
Few political contributions		.590						
Low campaign involvement		.584						
Church non-attendance		.522						
Low political interest		.486						
No club memberships		.444						
Dislike of theory		.417						
No membership in elderly groups		.384						
Shyness		.370						
Low income		.313						
Not feeling tense			.626					
Not pushed around			.601					
Can change things			.527					
Poor blame the system			.453					
Poor can advance			.442					

(continued on next page)

TABLE 1 (continued)

	1	2	3	4	5	6	7	8
Good memory			.422					
Not lonely			.383					
Unmarried				.773				
Female				.761				
No home-ownership				.524				
Age				.395				
Lack of job opportunities					.704			
Age discrimination problem					.589			
Emptiness of life					.429			
Dissatisfaction with programs					.421			
Government not too complicated						.607		
Trust in government						.588		
Government pays attention						.403		
Satisfaction with retirement							.636	
Need to keep busy							.466	
Registered to vote							.400	
Even-tempered								.603
Can resist cravings								.569
Not excited easily								.545
Non-imaginative								.374
Eigenvalue	7.66	2.87	2.48	2.11	1.81	1.67	1.62	1.49
Percent of variance	16.0	6.0	5.2	4.4	3.8	3.5	3.4	3.1
Overall factorial determination: 45.2								
N of cases = 200								

Note: Factor 1 = Poor Health; 2 = Disengagement; 3 = Self-Sufficiency; 4 = Female Aging; 5 = Meaningful Employment; 6 = Political Faith; 7 = Self-Starting; and 8 = Stoicism. All variables are derived from single questions except for three summative scales indicated by asterisks in the table: Physical infirmities (index of sight, hearing, missing limbs, obesity, palsy, speech, and mobility); Activity deficits (index of dressing, bathing, cutting toenails, reading, preparing meals, going outside for walks, climbing stairs, cleaning house, shopping, driving, using toilet, and standing from a sitting position); and Dissatisfaction with programs (index of 21 variables indicating dissatisfaction with government programs for the elderly, including cooking and delivery of meals, visitations, personal and home care, legal services, medical transportation, tax advice, discount privileges, social clubs, information and referral services, recreation, housing aid, emergency service, and home energy assistance).

individualistic orientations; see Feldman, 1982), sense of personal mastery over the environment (questions from an abridged version of Rotter's locus of control instrument), and lack of feelings of loneliness or tenseness. The tenseness or "stress" variable, which has been found to be related to several maladies of everyday life (Goldberger and Breznitz, 1982), seems to be intimately connected with one's sense of personal control. Moreover, the location of the memory-ability variable in this factor suggests its importance for one's sense of control over everyday life.

Factor 4 might be labeled "Female Aging." Its four items include being unmarried and female, not owning a home, and age. Females tend to live longer and, thus, outliving their husbands, tend to be unmarried. Given the likelihood of declining economic resources as females age and the lower availability of potential spouses, the lower rate of home-ownership in this factor is unsurprising. Note that chronological age falls precisely in this factor. Age, of course, is not completely unrelated to the other dimensions of everyday life. However, the data suggest that age per se represents a domain of elderly citizens' lives in its own right.

Factor 5 can be called the "Meaningful Employment" dimension. It includes perceptions of job opportunities, discrimination because of age, emptiness of life, and dissatisfaction with programs designed for the elderly. This combination of variables suggests a lacuna in current policies for the aged, namely a shortfall in linking programs to people's needs. Future policies designed to combat ageism in employment may need to address this concern. Ideally, these policies would reduce the sense of existential meaninglessness and enhance the feeling of life-fulfillment.

Factor 6 taps "Political Faith." Trust in government and political efficacy (the sense that one can have some political influence) load most heavily on this dimension. Note that the factor reflects only *beliefs*, in contrast to the Disengagement factor, which includes actual political *activities* (which, in turn, are intimately connected with education and income). This pattern suggests that the political mobilization of the elderly is less a function of faith in the political system and more a result of socioeconomic status.

Factor 7 we label "Self-Starting." Its items include happiness with retirement, desire to stay active, and (perhaps related to the desire to stay active) being registered to vote. Although some of the elderly may be dissatisfied with retirement because of occupational ageism, presumably those with self-starting dispositions can compensate with personally initiated activities.

Factor 8 suggests a purely psychological dimension of "Stoicism." Respondents scoring high on this domain assessed themselves as individuals

who are even-tempered, have a high degree of self-control, do not get too excited, and display a weak imagination. This factor may reflect a psychological compensatory mechanism to deal with the manifold difficulties of the biological aging process. It also may reflect the calmness and control acquired by some citizens from their long experience in handling the problems of life.

Noteworthy is the fact that most of the factors are at least bi-disciplinary and the most important ones are clearly multidisciplinary. Only Factors 6 and 8 might be described as discipline-defined. These findings demonstrate the utility of a multidisciplinary approach to the problems of the elderly. They underscore the need for a comprehensive orientation to conducting research, training gerontologists, formulating policies, and implementing programs.

Factor Validation

Factorial dimensions, however, should not be accepted blindly. If possible, they should be subjected to empirical validation. Given the breadth of the survey instrument, we were able to select a number of variables which failed to fall into the simple factor structure, but which could be used to substantiate the dimensional solution. Those variables were chosen which were expected to be significantly related to the factors, assuming that the dimensionality which was found empirically was valid. Space disallows a full listing of our expectations, all of which were relatively straightforward (e.g., the Poor Health factor should be correlated with poor diet). The correlations between these variables and the factors can also provide a check on our substantive interpretations of the dimensions.

Given the problems of potential error associated with computing factor scores for each case, a conservative strategy of constructing simple summative scales from the standardized scores on each variable was taken (see Kim and Mueller, 1978a, 1978b; McIver and Carmines, 1981). These factor-based scales were then correlated with the external variables. The Pearsonian coefficients which proved statistically significant are reported in Table 2.

The Poor Health factor, as expected, is associated with economic problems and poor diet, presumably its structural and biological causes. It is also connected with self-consciousness and a feeling of helplessness, presumably its psychological effects.

The Disengagement factor is related to dislike of people, having few friends nearby, and psychological withdrawal. It is strongly connected with

TABLE 2
Correlations of Factor-based Scales with External Variables

	PoHe	Dise	S-Su	FeAg	MeEm	PoFa	S-St	Stoi
Poor diet	.24***	—	-.16*	—	.14*	—	-.18**	—
Economic problems	.18**	.30***	-.25***	—	—	—	—	—
Unable to cope	.43***	.22**	-.23***	—	.14*	—	—	—
Feeling helpless	.29***	.24***	-.25***	—	—	-.14*	-.28***	—
Little control over life	.23***	.21***	-.38***	—	—	-.12*	—	—
Dislike of people	.22***	.23***			.12*	-.13*	.12*	—
Few friends nearby	.20**	.18**	—	—	.12*	—	—	—
No participation in support group	—	—	—	—	-.24***	—	—	—
Self-conscious	.13*	.15*	—	.14*	—	—	—	-.15*
Not assertive	—	.19**	-.16*	—	—	—	—	.26***
No need of emotions	—	.16*	.16**	—	—	—	—	.16*

Note: PoHe = Poor Health; Dise = Disengagement; S-Su = Self-Sufficiency; FeAg = Female Aging; MeEm = Meaningful Employment; PoFa = Political Faith; S-St = Self-Starting; Stoi = Stoicism. Single asterisks indicate one-tailed significance levels of .05; double, .01; and triple, .001.

economic problems, suggesting that social and political withdrawal has an economic basis, as was surmised above. The disengaged also feel an inability to cope with their problems. Unfortunately, they are somewhat less likely to participate in community support groups to enhance their coping ability.

Self-Sufficiency is related to better diet, few economic problems, a sense of control over one's life, and assertiveness. But this rugged individualism may have a psychological price tag; it is correlated with the belief that the emotions are not needed.

The Female Aging factor is correlated with self-consciousness. Elderly females, lacking age-mates and their own homes, appear to feel an acute sense of social marginality.

Meaningful Employment is related to nutrition (poor diet) and social relationships (few friends). However, those perceiving a lack of meaningful

employment are more likely to participate in community support groups. It is encouraging to note that such groups are indeed attracting those with retirement problems. Yet the items in this factor (perception of few opportunities and occupational ageism, and a dissatisfaction with government programs) suggest that these groups provide only limited coping resources. Indeed, lack of meaningful employment is associated with inability to cope.

Political Faith is associated to some degree with psychological sociability and personal efficacy (feelings of not being helpless and being able to control one's life). Political efficacy seems closely related to personal efficacy in daily life.

Self-Starters have better diets and feel they can help themselves. Their stronger dislike of people may reflect a greater reliance on personal than social resources.

Stoics are less self-conscious but also less assertive. This indicates effective emotional control on the one hand, but social caution on the other. Expectedly, these "cool elderly" feel little need for emotionality. In sum, the external validation seems to provide support for the factor solution.

Conclusion

We discovered eight distinct dimensions that make up elderly daily lives. Our findings tend to confirm and also extend the theoretical considerations of other gerontologists. Previous literature has accepted *a priori* the existence of several factors that help to define the life spaces of older citizens. However, these have been pronounced *ex cathedra*. In this article, the domains that constitute the daily lives of the elderly have been determined according to statistical analysis of data provided by the elderly themselves.

Some broad implications for policy formation follow from the factor analysis and external validation. Specifically, the findings may assist in assessing needs, configuring institutions, and gearing legislation and services to the neediest groups.

First, policymakers must know their constituents' needs. Information costs are high, however, and the needs, especially for the elderly, are many. The eight factors of our analysis, however, summarize a wide variety of needs and constitute a shorthand way to isolate the key concerns of the elderly. In addition, by knowing the scores of constituents on the two items with the highest loadings in each factor, a policymaker can estimate their rankings on other items in the dimension. Take, for example, the Poor

Health factor. By knowing the degree to which elderly citizens suffer physical infirmities and deficits in activities, a policymaker also has some knowledge of their sense of hopelessness and uselessness. The costs of needs assessment might therefore be correspondingly reduced.

Further, the external correlates of the factors provide additional useful information about needs. For example, the fact that certain elderly citizens have physical infirmities strongly suggests as well that they have economic problems, poor diet, and an inability to cope. These correlates imply that income supplements, meals-on-wheels, and similar services may be needed to help alleviate physical infirmities and other aspects of "poor health."

Second, the analysis suggests the desirability of a multidisciplinary configuration for public and private institutions. For example, the items in the Poor Health factor embrace three kinds of inadequacies: physical (such as activity deficits), psychological (feeling worthless), and interpersonal (few social contacts). The pattern hints that elderly citizens who score high on this factor are in need of services from a multidisciplinary "health team" of experts in medicine, psychology, and sociology. Otherwise, only some aspects of the poor health of these citizens will be treated. Likewise, the items of the Disengagement factor suggest that some of the aged suffer simultaneous deficits in politics (few contacts with bureaucracies), enlightenment (low education), and social life (few group memberships). The appropriate "engagement team," then, might include volunteers to enhance political participation (League of Women Voters), education (teachers), and social involvement (entertainers). In short, a "bits-and-pieces" approach to the problems of the elderly might usefully give way to a more holistic one, whose elements might well have a synergistic impact.

Third, the findings have implications for crafting legislation and gearing programs for the appropriate groups. The Female Aging factor, for instance, suggests that lack of home ownership is a particular problem for elderly women. Women's organizations, then, might be useful allies in pushing for housing legislation, which should have special provisions for elderly females. The Meaningful Employment factor indicates that mere creation of job possibilities for the elderly is not enough; anti-ageism legislation may be necessary to prevent discrimination. The Self-Sufficiency and Self-Starting factors suggest that some of the elderly have little trouble in fulfilling their needs, including accessing government programs. Those with greater dependency and less initiative, however, are less likely to take advantage of available services, especially if they suffer from physical problems (Peterson, 1987, 1988, 1990; Peterson and Somit, 1990). These citizens, therefore, should be targeted for aggressive outreach programs.

Note

1. Principal components analysis is used to isolate the number of key dimensions underlying a large set of variables. These principal dimensions or "components" might be viewed as the "magnetic poles" toward which indicators having common variance are attracted. The variables falling outside of the eight components constituted far weaker and uninterpretable dimensions. Theoretically, the decision to truncate the number of dimensions at eight was dictated, on the one hand, by the multifaceted nature of everyday life, and, on the other, by the desire for a data-reductive solution. Methodologically, while parsimony is a value, one is advised to err on the side of too many factors. Empirically, the scree plot revealed an elbow over nine dimensions, suggesting that the ninth and subsequent components were random noise (Kim and Mueller, 1978a; Gorsuch, 1983). The remaining variables thus appeared to represent less important or weaker, subsidiary surrogates for the items in the strong dimensions.

For the factor analysis, the conventional criterion of .3 for loadings was used to determine whether a variable should be included in the solution. Only 18 variables had a factorial complexity greater than one. Each of these had a complexity of only two. For each of these variables the highest loading, on its primary factor, made substantive sense. The additional loadings on secondary factors were theoretically uninterpretable or contradictory. None were larger than .41. Such chance loadings are not uncommon in factor analysis (Gorsuch, 1983). Thus, the extraneous loadings were omitted from the simple structure displayed in Table 1.

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The Rural Elderly: Providers' Perceptions of Barriers to Service Delivery*

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ABSTRACT

A 1989 survey of the State Units on Aging (SUAs) produced five themes that seem to underlie the many barriers to the delivery of services to the rural elderly. A systematic review of these five themes led to the identification of 34 specific challenges or barriers, which were then placed under the appropriate theme. Such a schema has been outlined in order to aid social service providers, researchers, and students in making sense of the problems faced by the increasing number of rural elderly. In addition, in order to assess the relative importance of these barriers, a second survey of 172 "resource persons" in the field of rural aging provided data showing, by theme, which barriers are perceived to be of most importance.

* Paper presented at the 55th Annual Meeting of the Midwest Sociological Society, Des Moines, Iowa, 11-14th April 1991. This research was supported, in part, by a grant, No. 90-AM-0349, from the Administration on Aging, Department of Health and Human Services.

In the many and varied regions of rural America, aging advocates and providers of programs and services for rural elders face a myriad of challenges. Such challenges, also referred to as "barriers," range from the very simple to the highly complex; from the painfully obvious to the obscure and ambiguous; from those easily overcome to those which are problematic.

These barriers are further complicated by the significant variation among rural regions of the country as well as by the notable rural diversity even within states and their sub-state regions and localities (Coward & Dwyer, 1991; Krout, 1986). Painting a consistent picture of rural America is thus very difficult. Some areas are experiencing significant economic growth, while many others are beset by chronic financial problems. Some have a relatively high density population, while others have very low population per square mile. In some small portions of rural America the programs and services that are generally accessible for elders are adequate, but in a significant number of other geographic areas, even the most basic of services are seldom available.

While the spectrum of barriers to service is broad and the diversity of rural America defies consistent definition, there are constants that characterize rural elders when compared to their suburban and urban counterparts. Older rural people, by almost all economic, health, and social indicators, are poorer (Kim, 1981; Coward, 1979; Auerbach, 1976); less healthy (Coward & Dwyer, 1991; Schooler, 1975; Ellenbogen, 1967; Youmans, 1967); live in poorer housing stock (Coward, 1979); have fewer options in personal transportation and less availability of transit services (Harris, 1978; Cottrell, 1971); and have significantly more limited access to health professionals and community-based programs and services (Coward & Dwyer, 1991; Ecosometrics, 1981; Frenzen, 1991; Krout, 1986; Nelson, 1980, 1983).

The list of deficiencies and inequities can be quite alarmng to those unfamiliar with the very real circumstances of many rural elders. It is often argued that being old and living in rural America is a form of "double jeopardy," where the individual is put at risk both by advancing age and by the circumstances of rural residence. Indeed, if other factors, such as being a member of a minority group or Native American tribe, are added to the argument, there is a case for "triple jeopardy."

Finally, it is also argued that urban assumptions about programs and services for older persons are often misapplied to rural realities (Coward, DeWeaver, Schmidt and Jackson 1983; Steinhauer, 1980). These assumptions are built upon stereotypical notions of the lives of elders in rural America. Perhaps the most common urban assumption is that rural life for older persons is more than adequate. A second common urban assumption

flows from the first: if life is good for rural elders then there is no moral or political imperative to aid them, since there is no need to alleviate problems that do not exist. A third urban assumption about rural America is that program and service costs are lower in nonmetropolitan areas, and a fourth assumption is that elders in urban, suburban, and rural areas have similar problems, amenable to like solutions and, thus, there is little city-country differentiation, much less an acknowledgment of the diversity of rural America itself (Kerckhoff & Coward, 1977).

To begin to systematize some of the basic themes underlying the barriers facing providers of services to the rural elderly, the National Resource Center for Rural Elderly, in 1989, completed a telephone survey of over 90 percent of the State Units on Aging. The major purpose of this article is to show that a large number of problems which, at first actually seem to be entirely unrelated and completely overwhelming, can actually be systematized. With such a system, the practitioner can gain clarity, realization that others face similar problems, and a knowledge of which problems can be solved with present resources and which problems are currently unsolvable. Such information can then aid the practitioner in correctly prioritizing those obstacles to be overcome. We have clustered the barriers brought to our attention under five major themes: (a) Isolation, (b) Economic, (c) Service Availability, (d) Culture and Demographic, and (e) Funding, Statutory, and Governance. Within each of these themes the major barriers are outlined.

I. Isolation Challenges

A. Distance as a Barrier

In our highly mobile society, many of us take for granted the ability to get into our cars and simply drive to a purveyor of needed goods and services. In many portions of rural America, however, this is a luxury for an older person. With the shrinking of many small towns and the concomitant growth of regional service and shopping centers, it is not uncommon for an older person to face a one-way drive of at least 25 to 50 miles to secure medical services or to purchase basic goods and nonmedical services. For the very old or frail rural elder, this can be an insurmountable challenge.

For the service provider the challenge is equally difficult (Parkinson, 1981). Many area agencies on aging have a multi-jurisdictional planning and service area. Organizing, managing, supervising, and evaluating programs and services over large distances can be a difficult task. Achieving

any benefit from economies of scale is difficult, and with the increasing cost of gasoline distance becomes a serious problem.

B. Terrain as a Barrier

Sheer distance is often compounded by serious geographic obstacles or a crumbling transportation infrastructure (Ambrosius, 1981). Impassable or difficult mountainous terrain, long sections of rivers stretching for many miles between bridges or ferries, areas of desert or swamp that only the bravest will attempt to traverse, or sway-backed and rotted bridges are as formidable a barrier as miles of open road.

C. Weather as a Barrier

A third highly obvious but equally serious isolation barrier is the weather. In some regions, particularly around the Great Lakes or in mountainous regions, one snowfall can mound several feet of snow at the door of a rural elder. In other areas, extreme cold can effectively preclude a needed journey or the delivery of services to the home. While cold is obviously a seasonal problem, the further north the planning and service area, the longer the winter season and thus the more drawn-out the period of difficulty. At the other extreme, heat can be as deadly as cold. A few summer hours in West Texas or Southeast Arizona can be as deadly as sub-zero temperatures in Montana.

D. Perception of Access

A fourth isolation barrier is less patently obvious, yet just as real. If rural elders perceive themselves to be isolated, then that perception is just as valid an obstacle. Many rural elders share this perception and overcoming this sense of solitude proves to be a difficult task.

E. Service Isolation

A fundamental problem is the simple lack of programs and services available, especially transportation services. Studies document a dearth of programs and services (Coward, 1991; Hicks, 1990; Hogan, 1988; Krout, 1991; Merlis, 1989; McKelvey, 1979). While a particular service or set of services may well be available in the largest population center in a specific planning and service area, it may not be generally available in all counties of that Public Service Area (PSA).

F. Minority Isolation

In addition, one isolation variable that is seldom discussed, yet can play a powerful role is minority status. Rural life as an older black, Native American, Hispanic or retired itinerant worker generally leaves much to be desired. Except in those regions where there is a high enough concentration of a minority population to overcome the sometimes blatant daily manifestations of discrimination, rural minority elders face all of the problems of their white counterparts, plus those difficulties imposed by their membership in a group not accepted or wanted by the majority of the population, regardless of age.

G. Political Policy Isolation

It would be extremely difficult to argue that the concerns of rural elders have been central to the emerging public policy debate on the problems and potentials of the older population in general. Indeed, many elders in rural areas are struggling to achieve some form of parity with their urban and suburban counterparts. Rural elderly advocates and service providers have not played as central a role in national policy debates as that played by their urban and suburban counterparts because many rural social and political movements face the challenge of organizing an isolated and widely dispersed constituency.

II. Economic Challenges

Unfortunately, many rural communities are tied to a single industry, crop, or service, which allows little, if any, control over major nationwide economic cycles or the similar swings attached to very specific product areas. While there is no simple solution to the economic problems of rural America, it can be argued that diversification is the main buffer against such swings. Within this context, each of the economic barriers to rural service provision is examined.

A. Lack of Rural Targeting of Federal and State Funds

Many federal and state formulas for dispersion of funds do not include a rurality factor when calculating the amount of money that will be made available for rural elders' programs and services (Ecosometrics, 1981; Kim,

1981). One highly questionable argument almost always used in attempts to promote and maintain the discrepancy between urban and rural funding is that rural costs for programs and services are lower than urban costs (Hendricks & Cromwell, 1989). Recent studies on health care costs, however, refute this fallacy (Straub, 1990).

B. Lack of a Strong Local Tax Base

In those states that contain economically depressed rural regions, county and town tax bases have been hard hit by the agricultural depression of the late 1970s to mid-1980s. Given the general paucity of federal and state funds, rural agencies have not been able to look to local tax resources to fuel programmatic growth. Even for those rural jurisdictions that are more economically viable, there is not the breadth of tax base to support expanded or new services.

C. Lack of Cost Sharing with Participants

In a discussion of cost sharing, proponents contend that some form of voluntary means testing is one method to extend funding for programs and services. Opponents claim it ignores the social needs of older persons and the needs of the oldest old and needlessly reinforces the "welfare stigma" that many older rural persons attach to various services. Regardless of these arguments, however, means testing is a concept that merits further formal debate.

D. Lack of an Adequate Pool of Local Fund-Raising Resources

Not only have rural economic problems negatively impacted units of government, this same financial downturn has had a negative impact on business and individual donations. Success in local fund-raising in the late 1970s and early 1980s appears to have become static in recent years.

E. Lack of Local Matching Capacity

Given the lack of rural local government revenues and the limited capacity to generate local charitable contributions, a major challenge facing many rural service providers is simply that of securing adequate matching funds for existing federal and state funds.

F. Lack of an Adequate Pool of Rural Volunteer Support

One traditional method of overcoming rural financial scarcity has been to rely on the use of volunteers. Given the phenomenon of aging-in-place due to the continuing out-migration of rural youth, this method is being severely tested because the pool of potential volunteers is shrinking.

III. Service Availability Challenges

The major barriers considered under this theme are simple to define but difficult to overcome. Two key questions bring us to the heart of the problem. First, to what extent must rural providers sustain a basic infrastructure of human services? Second, what will expanding the human service infrastructure cost?

A. Lack of a Human Services Infrastructure

Over the last several years, many sections of rural America have experienced a shrinkage in their general human services infrastructure (Hines, Green, and Petrulis, 1986). Examples are: (a) the permanent closing of nearly 200 rural hospitals, with many more in serious jeopardy (Merlis, 1989); (b) the shrinking availability of many goods and basic services in small towns and hamlets and the concomitant rise of distant regional service centers (Krout, 1986); and (c) the restructuring of rural transit systems, leading to the death or reduction of many private and public transportation routes (Krout, 1986; Grant, 1984). The consolidation of business services, transportation systems, and health care facilities continues, with no sign of reversal (Mick & Morlock, 1990).

B. Lack of Rural Elderly Service Providers

Despite the best efforts of many states and local providers, there are still some rural counties with no aging services and others where only the largest town offers even limited services. This uneven availability of services continues to be a problem with no signs of resolution in the near future.

C. Lack of High-Technology Equipment and Training

While high-technology equipment will probably never provide the panacea for rural elders' services, such advances could play a major role in

accessing certain types of services. The technology is currently available, for example, to adjust pacemakers over the telephone; to provide certain forms of health screening; to allow for video shopping using the postal service; to perform many banking transactions; and to complete a myriad of other financial transactions. The increasing use of personal computers may also open up many information and communication possibilities. Yet, for many rural service providers, such technology may well be inaccessible due to cost considerations and limited opportunities for training in the use of the equipment.

D. Lack of Rural Human Resources

Technology may cure certain woes, but it is paid staff and volunteers who will ultimately determine the quantity and quality of rural services for elders. The problem of rural recruitment and retention of qualified personnel, particularly in the health professions, continues to be a challenge for creative rural service management (Coward & Dwyer, 1991). In addition, service generalists are more commonly needed in rural areas, while American society as a whole is obsessed with the education and training of individuals in more and more highly specialized areas.

E. Lack of Multi-Purpose Regional Service Sites

Coordination of services at multi-purpose regional sites may not be operationalized in all rural sections of the country (Dwyer, Lee, and Coward, 1990). Given the ongoing regionalization of rural America, multi-purpose centers at strategically-located population centers throughout a planning and service area will not stem the tide of rural contraction. The barrier is simply having the funds to plan, implement, and maintain such centers.

F. Lack of Acceptable Services

An irony for many rural providers is that services which were once acceptable to rural elders are now faltering in acceptance by older people. The congregate meals program provides an unfortunate example of a service that was once heavily utilized but is now seeing shrinking participation in some rural regions (Krout, 1989). Rural providers must constantly reassess their funding and service priorities. Certain services may have to be reconfigured in order to achieve higher acceptability, and some may perhaps need to be discontinued.

G. Lack of Rural-Sensitive Needs Assessments

Rural-sensitive needs assessment is a highly specialized capacity generally beyond the limited time and staff expertise of a rural service provider or advocate. Even in those situations where the time and technical capability are available, there is often resistance to conducting needs assessments (Powell & Thorson, 1989). There is a changing perception of need among rural elders, however, and staying attuned to these changes requires ongoing attention.

IV. Cultural and Demographic Challenges

Instituting cultural changes and positively impacting demographic trends are the most difficult and time-consuming tasks to successfully accomplish. If there is to be change, then, rural service providers are going to have to gamble, and expect to face failure as well as achieve success. Governing boards, funding agencies, Councils of Governments, and local governments should thus be forewarned when exploring new cultural or demographic territory.

A. Lack of Intergenerational Contacts and Supports

The phenomenon of aging-in-place and the associated out-migration of the relatively youthful rural population leads to the social isolation of older persons in many rural regions. Not only is this form of isolation problematic in and of itself, it also has serious implications for the availability of a pool of younger volunteers.

B. Lack of Income and Knowledge of Government Entitlement Systems

For many rural elders, the relative lack of disposable income makes it impossible for them to make even minor good-faith contributions for programs and services. When this lack of income is coupled with a lack of opportunity for education about government benefit systems, the rural elder is unable to access entitlement programs for self-help.

C. Lack of Literacy

Adding to the lack of income and ignorance of government entitlements is the fact that there are some older rural adults who simply cannot read or whose reading skills are minimal at best (Ansello, 1981).

D. Lack of Minority Tolerance

Rural blacks, Native Americans, and Hispanics have long known that there is a lack of essential tolerance for minorities, while new immigrant groups who are penetrating some rural regions, particularly those of Asiatic origin, are quickly finding out about such barriers firsthand. This lack of tolerance further complicates the issue of service provision to the rural elderly.

E. Lack of Religious Tolerance

Religious differences often provide a significant barrier which is particularly acute in congregate programs such as senior centers, county focal points, and nutrition services. Unlike urban/suburban services, which often have enough individuals of a particular religious faith or creed to justify a separate service site, rural sites often find that elders will simply not participate if they must do so in the company of those not of their particular faith (Rogers, Burdge, Korsching, and Donnermeyer, 1988).

F. Lack of Willingness to Accept Help

A "nonacceptor syndrome" toward the use of services by rural elders, particularly the very old, has been identified in at least one section of the country (Ecosometrics, 1981). This syndrome involves an older individual's striving for independence, a generalized hostility toward those services perceived as "welfare," a staunch refusal to use needed services, and a persistent denial of acceptance of assistance actually given and received.

G. Lack of Individual Privacy

For the rural elder who has led an independent and individualistic life, acceptance of certain forms of service calls reveals, intentionally or not, certain factors about their life and economic circumstances. In rural services, where many of the participants are known to local officials and other members of the community, it is often quickly known that an older individual has utilized a program or service. This outcome is often a tremendous obstacle when the users are not eager to have their acceptance of a service or financial status known to the community at large.

V. Funding, Statutory, and Governance Challenges

The last theme to be reviewed is the realm of political control and geographic bias. The evidence strongly suggests that existing funding, statutory, and governance patterns are skewed toward the needs of the urban/suburban community (Coward & Dwyer, 1991).

A. Lack of Adequate Government Funding

Adequate funding is a fundamental prerequisite for the provision of programs and services for rural elders. Whether the source of funding is federal, state, or local, it is simply impossible to run most services if they are seriously under-funded. The blame for the relative lack of rural service funding lies primarily with the urban/suburban bias of those who provide the financial resources (Krout, 1986). Some of the responsibility for this situation, however, lies with rural advocates and service providers. In many rural areas, enormous amounts of time and energy are expended on local fund-raising efforts. If some of this time and energy were expended on federal and state level political action and coalition-building, the rewards would be much more substantial and the impact on the provision of services far greater (Watkins & Watkins, 1985).

B. Lack of Rural-Sensitive Federal and State Regulations

The federal and state government regulations which accompany monetary assistance often receive poor marks for perceived insensitivity to the attitudes, values, and beliefs of rural older persons and their ignorance of how programs and services operate in rural environments. This insensitivity is generally the result of government officials unconsciously giving urban values, practices, and procedures the virtual force of law without understanding the unintended rural consequences.

C. Lack of Rural Perspective

Urban/suburban stereotypes and biases form a powerful barrier to the provision of rural elders' programs and services. Rural advocates and providers have long had to defend against the urban contention that the costs of rural programs for elders are somehow exorbitant when, if the true

costs of urban/suburban programs are fully accounted for (including those costs covered through the infrastructure), this may well not be the case at all (Steinhauer, 1980).

D. Lack of Local Priority for Rural Aging Services

Rural programs and services for elders must compete for sparse local support and dollars with those interests which aggressively advocate for infrastructure support, such as road maintenance, bridge repair, county law enforcement, solid waste disposal, and other rural necessities. Even when not faced with economic decline, there is significant pressure on county, town, and village governments to keep tax rates as low as possible, particularly when the rates are tied to land valuations, so that agricultural and small businesses can maintain their generally slim profit margins. In recent years, large-scale corporate farm managers have added their voices to the low-tax chorus. The resulting small tax base makes competition for funding even more fierce.

E. Lack of Aggressive Service Provider Governance

On top of the low-tax mentality, many providers of services for rural elders often face an additional, institutional obstacle to their advocacy on behalf of older adults. In many sections of the country, area agencies on aging and their service providers are governed by a consortium of elected county and town officials combined into a regional council of governments (COG) or some other form of regional intergovernmental cooperative. With this form of governance, the same low tax political pressures that beset these elected officials in their respective jurisdictions are carried into the decision-making circles of the COG.

F. Parochialism and Lack of the Long View

Parochialism mixed with chauvinistic pride often provides a serious obstacle to the provision of rural elders' programs and services. There is often an assumption that a provider in one rural region of the country simply cannot understand the problems and peculiarities of a fellow provider in another section of the nation (Ecosometrics, 1981). There is a related assumption that there is little, if anything, that is exportable from urban/suburban programs to rural services.

G. Lack of Coherent, Modern Political Boundaries

The boundaries of the majority of states and counties were formed in the late 1700s and the early years of the 19th century. With these occasionally arbitrary lines drawn long before the advent of rural regionalization and modern forms of transportation, communication, and access, it is little wonder that outmoded political boundaries can form a major barrier to the provision of services to rural elders. It is also no surprise that occasional problems occur when a rural elder is denied a particular program or service by virtue of living on the wrong side of a boundary.

Relative Importance of Barrier

In order to get a feel for the relative importance of these 34 barriers or challenges to the delivery of services to the rural elderly, we decided to mail a short questionnaire to 172 "Resource Persons" whom the National Resource Center for Rural Elderly had identified who could be used for technical assistance and training by service providers. Included were members of the aging network from federal, state, and area agencies; university faculty; private consultants; members of related government agencies at all levels; and members of not-for-profit organizations. The results of this mailed questionnaire are now briefly outlined. Respondents were asked to place each of the 34 barriers on a scale from 1 to 10 with 1 being "of least importance," and 10 being "of most importance." At the end of the questionnaire each respondent was asked to rank the top three factors out of the 34 they had just rated.

Results

One hundred and seventy-two questionnaires were mailed in February 1991 and a total of 121 were returned for a response rate of 71 percent; 107 usable responses were tabulated.

The ranking of barriers under the first major heading, which was "Geographic Isolation Factors," indicated that "Lack of local services" was the most important factor (8.0 on the 10-point scale), "Distance" was the second most important (7.5), and "Terrain as a barrier" (3.9) was the least important.

The ranking of factors which we had placed under the label "Economic Factors" showed that "Lack of rural targeting of Federal and State funds" (7.4)

and "Lack of strong local tax base" (7.3) were most important. The least important factor seemed to be "Lack of a pool of rural volunteer support" (4.6).

The ranking of the barriers which were drawn together under the heading of "Service Availability Factors" showed that "The uneven distribution of service providers" (6.9) was most important and the "Lack of a human services infrastructure" (6.8) was second most important. The least important barrier was the "Lack of high-technology equipment" (4.6).

The ranking of the barriers clustered under the heading "Cultural Factors" showed that the most important barrier was "Lack of knowledge of government entitlement system," (6.5) and the second most important barrier was the "Lack of willingness of the elderly to accept help" (5.9). The "Lack of religious tolerance" (3.9) was the least important barrier.

Under the heading of "Statutory and Governance Factors," the highest ranked barrier was "Lack of adequate government funding" (7.9), with "Lack of rural-sensitive government regulations" (7.1) a close second. A third barrier, "The lack of rural perspective by government," was ranked almost equal with the second barrier (7.0). At the bottom of the rankings was "The lack of coherent political boundaries" (3.8).

Table 1 is used to illustrate the responses to the last question on the questionnaire, where respondents were asked to give a final ranking to the top three factors. The data shows that six factors were seen as most important. Two factors easily topped the list: "Lack of adequate government funding" and "Lack of targeting of funds." These two barriers were followed by four others which were given almost equal weight: a) "Lack of a human services infrastructure," b) "Distance," c) "Lack of rural-sensitive regulations," and d) "Lack of local services to overcome isolation, mainly transportation."

Table I

Rank Order of Top Three Barriers

Rank	Factor	Times Position Ranked			
		1st	2nd	3rd	Total
1	Lack of adequate government funding	27	16	8	51
2	Lack of targeting of Federal/State funds	17	15	10	42
3	Lack of human services infrastructure	7	8	12	27
4	Distance as a barrier	9	8	6	23
5	Lack of rural-sensitive government regulations	3	12	7	22
6	Lack of local services	10	7	3	20
7	Lack of high-technology equipment	0	1	3	4
8	Lack of elderly to accept help	2	1	1	4

Conclusion

The purpose of this article is to provide a schema for classifying what, at first, seemed to be a large and diverse set of perceived barriers to the delivery of services to the rural elderly. The role we have taken is that of the applied sociologist; first, organizing this assortment of seemingly unrelated barriers, as perceived by most of the State Units on Aging, and then, second, collecting data from a more widely representative sample of service providers in order to rank the importance of such barriers. With this data we are able, as social gerontologists, to reinforce the connection between the university and the aging network by showing not only the common themes which underlie our schema, but also the importance of using the data as a basis for future decision making. Such information will allow those persons allocating resources and drawing up regulations to more efficiently target their efforts as we now recommend.

With the presentation of the data on the ranking of the perceived importance of each barrier, we have shown that even if increased resources cannot be provided by the major levels of government—the obvious perceived first priority—then certain other actions can be taken. First, there should be greater targeting of what funds are available. Second, there must be much more emphasis placed on the sensitivity of regulations to rural issues and rural diversity. Finally, an effort must be made to stop the erosion of the rural service infrastructure, with special emphasis on transportation to overcome the distance barrier. Specific solutions to the 34 barriers are available (Bull, Howard, and Bane, 1991), as is the full set of data showing the individual rankings of the barriers by sub-populations of respondents.

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