First Edition

40 Issues for an Aging Society

A Guide for Students

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Dedication

I want to thank my son, Evan Cotter, of Order Design, http://www.order-design.co/ . He encouraged me to turn this into this ebook and he did the hard work of making that happen. Ashley Harland helped me with editing, and my friend and colleague, Ellen Netting, PhD, edited and gave me great ideas, but let's be clear, all the mistakes are mine. Thanks to my main cheerleader, my wife, Ayn Welleford, PhD, for her encouragement and her leadership in Gerontology at VCU, and a shout-out to all my students and colleagues who have informed my understanding of aging issues.

Preface

We have a new frontier of age and aging.

40 Issues for an Aging Society presents the problems, issues and trends I see as most critical to understanding the changes faced by our aging society. An issue by definition implies disagreement because there are alternative perspectives about how to resolve it. A better knowledge of all these issues will help you: 1) to better work with older persons to adapt to these changes, and 2) to assist society to deal with a growing population of older people. Beginning with some cross-cutting trends, I then consider three key areas: 1) health, 2) finances, and 3) social issues. There are numerous works on biological aspects of aging (including many about diet, exercise, meditation, etc.), and the other key area of gerontology, the psychological aspects of aging. Although we may touch on topics from each of these fields, neither is our focus.

In each chapter I present a brief background, based on research, of the key aspects to the issue and itsimplications for our society. I then offer some websites to explore. (I have checked the links right before publication. By the time you're reading this though I'll bet 20% need updating. You can try pasting the link into your browser window or just the Google the site and you'll find it.) I also offer suggestions for further research from academic sources where the student can obtain more scholarly information about the issue. Gerontology is about entrepreneurship and I present some brief thoughts on which business sectors may prove opportune for you to consider for a career. The final section offers thoughts on policy and political controversies that may emerge around each of the issues.

In this work, I want to encourage a broader understanding of aging issues, of how changes in our society will permanently alter the nature of health, retirement, caregiving, end-of-life care and many other areas. This book is only a starting point, but a starting point in 40 areas. This book is grounded in research and written as an introduction to aging issues for students. I hope it turns out to be helpful to a broader audience, including people engaged in aging and caregiving and retiring who find themselves wanting to understand the broad impacts of the achievement of so many older persons alive in the society.

The Aging Tide is coming in. We have a new frontier of age and aging. In 1900 about 1 in every 20 persons was old, by 2030, it will be 1 in 5. The fastest growing population group is those over age 85. You students have chosen an exciting career in a fascinating time. It's your responsibility to understand the trends and to apply your ideas so we can improve eldercare and explore and celebrate our aging society. Good luck to you as you tackle this marvelous new world of aging America in the 21st century.

J. James Cotter, PhD

General Issues

The Challenge of Personal Responsibility

The societal safety net for older people is shrinking. Government support for older persons remains strong but is under attack. The strains of expenses at the Federal and state levels mean cutbacks for all including older persons. Rollbacks in Medicare and Social Security are probable.

Corporate support for retirement through pensions and retiree health care benefits is fading. Smaller families, more geographically distant cannot provide the care in the same way as large, close extended families did in the past. Yet, older persons feel healthier than ever, live longer, and have fantastic opportunities to remain vibrant members of society.

It's an era when people can and must take more responsibility for all aspects of their own aging.

Americans have always grappled with a pendulum of public policy approaches in the U.S. We swing from an emphasis on mutual support to the ideal of self-sufficiency. What should the public do and what should the individual do? That's the American dilemma. We will always rely on family and friends and volunteers and non-profit agencies to care for older people

with the addition of government money when needed. As in the African proverb, we know "It takes a village to raise a child." But Americans have always stressed the responsibility of the

individual. Now, the pendulum is swinging back to an individual focused society.

It doesn't matter which party is in office. Each older person must take more responsibility for him/herself. They must build and manage their livelihood, their finances, their health, and their lives.

How will retirees pay for 30 years of retirement and leisure? How will they pay for increasing amounts of health care? Where will they live? What must they do to stay healthy and fit? What kind of 90 year old will that 60 year old be? These are some of the questions we all need to answer.

CHECK OUT THESE WEBSITE RESOURCES:

The International Coach Federation:
http://www.coachfederation.org/ICF/

The American Association of Nurse Life Care Planners:
http://www.aanlcp.org/

The 360-Degree Retirement
http://coachingteam.blogs.com/retirement_360/

SUGGESTIONS FOR FURTHER RESEARCH

Finding Your Own North Star: How to Claim the Life You Were Meant to Live, by Martha Beck.

For those looking at medical complications, see *Life Care Planning and Case Management Handbook* by Roger O. Weed

BUSINESS OPPORTUNITIES

Life coaching, the art of helping someone figure out where they want to go in life, is a fast growing business and involves psychology, law, finances, and health. Other opportunities can be found in retirement planning, health care planning and case management for persons with medical issues.

POLITICAL ISSUES TO WATCH

As economic times change the amount of mutual support and government assistance that older persons need changes. In a downturned economy, they'll want more help from others, including governments. In a strong economy, they'll need less help. And, the needs of older persons will always be competing with other social issues the society must address. Learn more by working with elder advocacy groups.

Baby Boomers: A generation or 77 million individuals?

After all the talk about the baby boomers, the age wave, it's here. (I should say we're here for I am a baby boomer.)

Boomers are the largest age segment of the US population. 77 million strong. 17th largest nation in the world. We have shaped and reshaped history, Civil Rights, JFK, Watergate, Vietnam, media, and sexual mores. We are the pig in the python, stretching the society from the inside out as we grew up and never fully digested. Just as boomers changed the schools and the workplace, we will change retirement. We are everywhere – their music is in stores, on ads. (It is a little disconcerting to hear revolutionary rock and protest songs as Muzak in department store elevators.)

The first boomers turned 65 in 2011 and every 7 seconds there's a new elder boomer. Think about it: almost ¼ of the society could be retired and out of the workplace. What will they do? What will the society look like when one in every five

persons is an older person? What about thirty years of retirement – who's ready?

Yet, keep in mind, all 77 million don't turn 65 in 2011. It's a gradual process over twenty years, less of an Age Wave and more of an Aging Tide. We'll add 3-4 million per year, and, in many ways, we won't even notice it. By the time the last turn 65, many of the early boomers will have moved on to their next karmic existence. So, I don't go along with the crisis approach to the success of American aging.

Who are the boomers? We're very diverse and our identity as a group may be more the creation of marketers than a real, cohesive segment. As we age, we'll become more diverse. We are as varied as the rest of the American population.

Baby boomers will transform aging and retirement. We will live longer: average life expectancy, once we reach 65 equals 84 years. Our pension and retirement prospects are good but many of us will need to save more.

Take a look at what opportunities the aging baby boomers offer you. Educate yourself about the needs and wants of the baby boomer generation.

CHECK OUT THESE WEBSITE RESOURCES:

SUGGESTIONS FOR FURTHER RESEARCH

For a positive view of their retirement, see Baby Boomer's Retirement Prospects: An Overview by R. Shackleton, Congressional Budget Office, 2003.

BUSINESS OPPORTUNITIES

A consumer group of over 70 million – where aren't there opportunities? Ah, but are they as similar as they are portrayed? Still, they will want to stay young (anti-aging services), they'll spend well (financial and consumer goods industries), they'll consume health care (especially medical care and pharmaceutical products), and many will want to pursue second careers or part time work (employment services).

POLITICAL ISSUES TO WATCH

70 million voters! If they come together over an issue watch out. The biggest issue needing a political solution is health care, Medicare, is already in fiscal trouble. Will the baby boomers tolerate severe reductions or vote for new taxes?

How old is old anyway? The Changing View of Age

How do you know when you're old?

- **A.** It's the number of years since the date on your birth certificate.
- **B.** It's how much more effort it takes to walk up that long hill.
- **C.** It's when society tells you you're old.
- ✓ **D.** All of the above.

Check Answer

• Age 40: A person qualifies for protection under the Age Discrimination in Employment Act.

• Age 50: Can join the largest older persons group in the world – AARP.

• Age 55: Many can qualify for early pension or retirement.

• Age 60: Qualify for services under the Older Americans Act.

• Full Social Security retirement benefits and Medicare are available at age 65 (gradually moving up to age 66-67 for those born in 1938 and after).

• Age 75: The traditional age for the beginning of frailty.

• Age 85: Often referred to as the old-old.

But 'the times, they are a changing':

Adriana Iliescu, at age 66, gave birth to a baby girl in January, 2005 through reproductive technology.

Yuichiro Miura climbed Mount Everest at age 70.

John Glenn at age 77 flew on the space shuttle, Discovery.

Paul McCartney became a father at age 60.

The traditional constraints that say 'if you're 50, you can't do that', 'if you're 60, you can't do that', 'if you're 90, you can't do that' are fading.

Ken Dychtwald, in his excellent work, Age Power, suggests a change in the way we look at older ages. He suggests some new categories:

Middlescence – 40-60 years of age,

Late adulthood – 60-80, and

Old Age- 80-100.

So a person might retire into late adulthood? Some will be retired for almost half as long as they worked. In the past, society decided the stage of life for a person based on chronological age, but in the future, the individual may have more say over when those life stages begin. It's imperative to find vibrant seventy-year olds who can serve as your role models.

The best definition of old – ten years older than your current age.

CHECK OUT THESE WEBSITE RESOURCES:

The US Equal Employment Opportunity Commission: http://www.eeoc.gov/facts/age.html

American Association of Retired Persons (AARP):http://www.aarp.org/

Gerontologist Ken Dychtwald and the Age Wave:http://www.agewave.com/about/index.php

The US Administration on Aging and the Older Americans Act http://www.aoa.gov/OAA2006/Main_Site/

SUGGESTIONS FOR FURTHER RESEARCH

Rowe, J.W. & Kahn, R.L. (1999) Successful Aging. New York: Pantheon Books. Old but classic.

BUSINESS OPPORTUNITIES

Think in terms of extending traditional marketing to older age groups, and adjusting products and services to accommodate some minor limitations in physical activities. Products and services for grandparents who will probably take a more active role in their grandchildren's lives. Adaptive services and products that assist older persons to carry on activities despite minor limitations of chronic disease, e.g., disguised assistive devices such as earrings as hearing aids, fanny packs as oxygen dispensers.

POLITICAL ISSUES TO WATCH

Increase in age discrimination suits and pressure on courts to respond more positively to such actions. Continued debate about any benefits, e.g., tax reductions, Medicare, Social Security, given to those over a certain age.

G

What's the life expectancy? Better plan on 100

We have achieved immortality – at least that's what an ancient Roman, with an average life expectancy of 20 years, might think of our average life expectancy of almost 80 years. In twenty-first century America, life expectancy has almost doubled, up from 45 years in 1900. For the most part, increased life expectancy is due to vaccinations, public health, improved sanitation, and better nutrition.

What's more important for older persons is how long they might expect to live based on their current age. Age-specific life expectancy is the number of years a person lives after reaching a specific age. Advances in medicine and health care keep increasing the number of those years.

Check the chart of life expectancy at different ages:

Age	Life Expectancy
35	80
45	81
55	82
65	84

Source: CDC, US Life Tables, 2003

Life expectancy may be greater or less depending on lifestyle, ethnicity (inequality persists), and environment. Many will live much longer. Centenarians are the fastest growing segment of the population. Of the three, lifestyle activities have the most in-

fluence – exercising, eating well, and staying passionate about life. To estimate life expectancy, try one of the Web-based calculators below. There's a whole industry springing up, the Anti-Aging Movement, to foster longer life, but those three activities are the key. Go on. Put this book down. Go take a brisk walk, have an apple, take a friend and ride a rollercoaster.

CHECK OUT THESE WEBSITE RESOURCES:

Although there are many life expectancy calculators, I like the one from Dr. Thomas Perls, a scholar on centenarian: http://www.livingto100.com/

SUGGESTIONS FOR FURTHER RESEARCH

Again, look at the classic: Rowe, J.W. & Kahn, R.L. (1999 Successful Aging. New York: Pantheon Books.)

Newman AB, Glynn NW, Taylor CA, Sebastiani P, Perls TT, Mayeux R, Christensen K, Zmuda JM, Barral S, Lee JH, Simonsick EM, Walston JD, Yashin AI, Hadley E. (2011). Health and function of participants in the Long Life Family Study: A comparison with other cohorts. Aging (Albany NY). 2011 Jan 11. PMID: 21258136

Rice, D. P. & Fineman, N. (2004). Economic implications of increased longevity in the United States. Annual Rev. Public Health 2004. 25:03.1–03.17

BUSINESS OPPORTUNITIES

Financial and lifecare planning for 35 years of retirement (65-100 years of age)! Adaptable housing. Travel and recreation programs for older persons. Support with the basic tasks of housekeeping, home health care and other forms of long-term care.

POLITICAL ISSUES TO WATCH

Continued strides in life expectancy after the age of 65 put added pressure on government programs of Medicare and Social Security. If the very old-old outlive their financial resources, increased reliance on government programs will be necessary. Paying for these programs will result in tough debates about the capacity and role of government. Inequitable access to the medical procedures and services that support increased longevity.

Health Issues

Every day in every way older persons are doing better and better

One of the more frightening aspects of older ages is the potential of frailty and disability. Having a stroke at 75 and living until 85 is not the ‘golden years’ of retirement.

Yet, new groups of older people are living with more health and vigor. Yes, people can expect to live more years without growing frail and disabled.

A physician researcher named Jim Fries has tracked the health of the older population since 1980 when he came up with the concept of the “compression of morbidity”. The term describes a situation in which the average age at which a person becomes disabled is closer to the average life expectancy. Thus, the period of infirmity will be reduced, i.e. compressed between date of onset of disability and date of death. Other researchers have confirmed his findings in numerous studies. If the trends hold, older persons can expect to have significantly less disability than individuals in the cohort of older persons behind them.

What are the most common conditions and disabilities encountered as one ages? The leading causes of death are heart disease, cancer, stroke, and respiratory diseases. Other important diseases for mortality in older persons are diabetes, Alz-

heimer's disease, infections, renal diseases, and falls. These can all lead to disability and loss of functional independence in old age.

To promote a healthy old age people must follow a healthy diet and exercise. These are the best ways to ensure an active aging that limits the amount of disability.

CHECK OUT THESE WEBSITE RESOURCES:

The Center for Disease Control - search for Trends in Health and Aging: http://www.cdc.gov/nchs/

A site about aging women with applicability to all: http://www.womenshealth.gov/aging/

SUGGESTIONS FOR FURTHER RESEARCH

Fries J.F. (2003). Measuring and monitoring success in compressing morbidity. Ann Intern Med. 2003 Sep 2;139(5 Pt 2):455-9

Mor V. (2005). The compression of morbidity hypothesis: a review of research and prospects for the future. J Am Geriatr Soc. 2005 Sep;53(9 Suppl):S308-9.

Kramarow, E., Lubitz, J., Lentzner, H. & Gorina Y. (2007). Trends In The Health Of Older Americans, 1970–2005. Health Affairs, 26, no. 5 (2007): 1417-1425

BUSINESS OPPORTUNITIES

Active lifestyle products and services. Products that deal with managing chronic disease symptoms, e.g., adaptive equipment for maintaining active lifestyles, supports for older persons traveling.

POLITICAL ISSUES TO WATCH

On the one hand, the effects of a substantial compression of morbidity may result in a lower rise in health care costs than projections based on current levels of disability thus reducing the draw on Medicare funds. This issue would also support continuing involvement of older persons in politics including older office holders and participation and leadership in political parties. On the other hand, increased use of screening and restorative therapy, e.g., may drive health care costs higher.

Lifestyle versus Genes

Life is always about the interaction of nature and nurture, of genes and the environment. Genetic factors, by themselves, are rarely the sole source of disease. Rather it is the interaction between genetic predispositions and the environment that allows a disease to manifest itself. Lifestyle, e.g., regular exercise and proper diet, may reduce the chances that a genetic predisposition to chronic diseases such as type 2 diabetes, many cancers, and cardiovascular disease, will express itself. In other cases, such as levels of HDL cholesterol, genes may play a larger role.

Appropriate exercise and eating improves health and protects against disease. Healthy aging is a product of the combination of genes, lifestyle and the environment. Diet and exercise are the key elements. Why? Because they are the ones most under an individual's control. Nutrition counseling, up until now, has focused on obtaining enough nutrients. With adequate food available to more people, the focus is changing to counseling about the overabundance of food. A healthy lifestyle is founded on a moderate diet and daily exercise, including resistance training and aerobic workouts, and a diet that includes more fruits and vegetables. Exercise in small segments also helps– park

farther away and walk more, climb at least one flight of stairs, stretch while watching TV.

Remember that no matter what the genes say, the individual increases the rate of aging with poor lifestyle choices. The problem is the uncertainty of genetic predispositions. Technologies are beginning to identify these predispositions. Then specific lifestyle activities might counteract genetic tendencies.

The American Heart Association recommends the following: 1) minimize saturated and trans fatty acids in the diet; 2) don't eat food with extra sugar put into it; 3) use physical activity and control weight; 4) eat lots of vegetables, fruits and whole-grain foods; 5) avoid tobacco products; and 6) check and keep healthy your cholesterol, blood pressure and blood glucose levels.

It's not a hard lesson – activate good genes with a good lifestyle - eat less and exercise more.

CHECK OUT THESE WEBSITE RESOURCES:

Exercise and Physical Fitness: This site has it all. The information from the National Library of Medicine and the National Institutes on Health covers many aspects of physical fitness. http://www.nlm.nih.gov/medlineplus/exerciseandphysicalfitness.htmlc

and
http://www.nlm.nih.gov/medlineplus/nutritionforseniors.html

The American Council on Exercise is the largest nonprofit fit-

SUGGESTIONS FOR FURTHER RESEARCH

Mcdermott, A.Y.& Mernitz, H. (2006). Exercise and older patients: prescribing guidelines. American Family Physician, 74 (3): 437-44.

Kennedy, E. T. (2006). Evidence for Nutritional Benefits in Prolonging Wellness. American Journal of Clinical Nutrition, 83 (2):410S-414S.

BUSINESS OPPORTUNITIES

Exercise coaches, health clubs, personal trainers, yoga centers; nutritional counselors and low-fat, low-sugar prepackaged meals; genetic counselors. Products and services that increase the exercise realized from daily activities, e.g., weighted exercise shoes, wrist weights..

POLITICAL ISSUES TO WATCH

As the costs of health care rise for employers and governments, watch for more and more debates on nutrition and exercise recommendations. Expect focus on mandating exercise programs in schools and workplaces. The debate over what foods to include in school and work cafeterias is already in full swing.

The more you eat – the sooner you die

The search for the secrets of eternal youth has gone on since before Ponce de Leon was born. Now, instead of water from a special spring, the search centers on changes in cell function with age and a genetic link to aging. Creams and salves and vitamins and herbal remedies are all touted as anti-aging. Drugs improve health and life expectancy. Many older persons have already cheated death by addressing early breakdowns in their body such as hypertension, diabetes, and cardiovascular conditions. But the secret to maintaining a youthful, vital body and mind eludes us – or does it?

The only known, and proven, way to maintain youth for a longer period than normal is caloric restriction. In every species, from worms to humans' genetic cousins, other primates such as chimpanzees, restriction of the amount of food consumed, coupled with excellent nutrition, has resulted in healthier bodies and more active minds. However, due to the length of human life, we have no true experiments with humans of a nutritionally dense, calorie restricted diet for long periods of time.

We do know that some of the biomarkers of age do improve when humans are on caloric restricted diets. The Biosphere2

was an experiment in self-contained living where eight humans were sealed inside an environment for two years. Due to some unpredictable food shortages, for most of the period they were

on a low-calorie, nutrient dense diet. The members of Biosphere2 experienced a weight loss averaging 17 pounds. Blood pressure decreased, immune system function improved, blood sugar levels decreased, as did cholesterol. Their health, both mental and physical, was excellent and their energy productive. A recent study showed that a caloric restriction diet cured Type 2 diabetes.

So why doesn't everyone follow a caloric restricted diet and live longer and healthier? The restrictions are severe. In most of the experiments, it was a thirty percent cut in calories, a severe enough drop to make it unsustainable for human tastebuds. However, the basic principle suggests that under-consumption of food, coupled with nutritional adequacy, will have a beneficial effect on the aging process. Likewise an overconsumption of food may lead to diminished capacity and earlier death.

CHECK OUT THESE WEBSITE RESOURCES:

The Caloric Restriction Society:
http://www.calorierestriction.org/

The National Institute on Aging of the National Institute on Health: This Age Page document, In Search of the Secrets of Aging, reviews current research on what causes the aging process and includes a chapter on caloric restriction.

SUGGESTIONS FOR FURTHER RESEARCH

Walford, R.L., Mock, D., Verdery, R. & MacCallum, T. (2002). Calorie Restriction in Biosphere 2:Alterations in Physiologic, Hematologic, Hormonal, and Biochemical Parameters in Humans Restricted for a 2-Year Period. The Journals of Gerontology Series A: Biological Sciences and Medical Sciences 57:B211-B224.

Dirks AJ & Leeuwenburgh C. Caloric restriction in humans: potential pitfalls and health concerns. Mech Ageing Dev. 2006 Jan;127(1):1-7. Epub 2005 Oct 13. Review.

Lim, E.L., Hollingsworth, K.G., Aribisala, B.S., Chen, M.J., Mathers, J.C. & Taylor, R. (2011). Reversal of type 2 diabetes: normalisation of beta cell function in association with decreased pancreas and liver triacylglycerol. Diabetologia DOI 10.1007/s00125-011-2204-7

BUSINESS OPPORTUNITIES

Nutrition consultants; laboratory testing; diet plans and vitamin supplements. Develop restaurants and eateries that use quality food that tastes great and is good for you, e.g. Chipotle.

POLITICAL ISSUES TO WATCH

The continuing debate over dietary guidelines offers a rich venue for observing the interface between federal regulatory agencies such as the Food and Drug Administration, the major federal research agency, the National Institute on Health, consumer advocates and the food industry. Although caloric restriction likely will not enter the debate, the role of diet and the responsibility for the obesity epidemic will continue to cause conten-

So if you use Viagra, do you still need a condom?

A common misconception is that age eliminates sexual relations. In various studies, a majority of people over the age of 60 report they engage in sexual activity on a regular basis. Estimates vary from 50-70% of older persons. This is not to say that sexual activity does not taper off somewhat, due to a variety of physical, psychological, and social factors. Physical changes require an adjustment to the aging body's hormonal and anatomical changes. Psychological changes occur based on stress, depression and a refocus of life interest. Social changes occur as partners change or partners are lost through separation or widowhood.

Yet, sexual activity remains an important part of older people's lives. Drugs for erectile function are a major pharmaceutical profit center. This is not surprising; sexual activity is bound up with physical and emotional intimacy. Sexual activity for older people does not mean a singular focus on intercourse, but rather includes a wide range of ways of expression, from hand holding to sensual touch.

Also, what many people fail to realize is that some of the sexual activity of older persons does not take place within the context of a monogamous relationship. Although having a partner is an

encouraging factor for sexual activity in later years, not everyone has a partner and not all partners are faithful.

Further, many do not understand the importance of using protection during sexual activity. As could be expected, the prevalence of HIV and AIDS is rising in older persons with 10.2% of AIDS cases diagnosed in 1995 over the age of 50 and 3.5% over the age of 65. The rate of increase is a stiff 71% over a two year period. Although this is a small number relative to the epidemic, the expectation is that the incidence will increase.

A related issue is that physicians and health care providers are often reluctant to discuss sexual activity with older persons. A sexual history is often not a component of a total physical assessment.

CHECK OUT THESE WEBSITE RESOURCES:

Global Action on Aging (GAA), affiliated with the United Nations, addresses older people's needs and potential, including sexual activity, and advocates for older persons around the world: http://www.globalaging.org/health/us/sexelderly.htm

American Psychological Association site: http://www.apa.org/pi/aging/resources/guides/sexuality.aspxl

SUGGESTIONS FOR FURTHER RESEARCH

Lindau ST, Leitsch SA, Lundberg KL, Jerome J. (2006). Older women's attitudes, behavior, and communication about sex and HIV: a community-based study. J Womens Health (Larchmt). 2006 Jul-Aug;15(6):747-53.

Addis IB, Van Den Eeden SK, Wassel-Fyr CL, Vittinghoff E, Brown JS, Thom DH. (2006). Reproductive Risk Factors for Incontinence Study at Kaiser Study Group. Sexual activity and function in middle-aged and older women. Obstet Gynecol. 2006 Apr;107(4):755-64.

Camacho ME, Reyes-Ortiz CA. (2005). Sexual dysfunction in the elderly: age or disease? Int J Impot Res. 2005 Dec;17 Suppl 1:S52-6. Review.

Mack, K. A. & Ory, M.G. (2003). AIDS and Older Americans at the End of the Twentieth Century. JAIDS Journal of Acquired Immune Deficiency Syndromes: 1 June 2003 - Volume 33 - Issue - p S68–S75

BUSINESS OPPORTUNITIES

Sexual aids and manuals geared to older persons; erectile dysfunction drugs and lubricating oils; generally romantic notions geared to an older market; dating and escort services for older adults.

POLITICAL ISSUES TO WATCH

HIV/AIDS is a tricky issue and we'll continue to see a lack of focus on prevention of sexually transmitted diseases for the older population. However, sheer growth in numbers as the aging population increases will slowly bring the issue to the fore, again and again.

Three glasses of red wine is beneficial – per week, not per day.

Moderate use of alcohol is associated with a decreased propensity for cardiovascular problems. Numerous studies indicate the association between the ingestion of 1-2 drinks per day and some health benefits.

What is one drink? One drink is 1.5 oz of liquor (a normal shot), 4-5 oz of wine, or 12 ounces of beer. So when we say that moderate alcohol consumption may have beneficial effects, keep in mind that 1 drink per day would be ONE beer, or ONE shot, or ONE glass of wine.

As to which to drink, there seems to be slightly more evidence for the consumption of wine than for the other kinds of alcohol. One study of French men even suggested that 2-3 glasses per day may have beneficial effects on cardiovascular disease and cancer. (But, it is unclear whether there is some other dietary or activity factor that may affect these results.) The benefits may come from the grapes rather than the alcohol so grape juice may be an option.

While sipping that glass of Cabernet, keep in mind that overuse of alcohol is risky for older persons. Any potential benefits must be weighed against the potential damage to heart and liver and kidneys from excessive alcohol consumption. Due to changes in metabolism, alcohol has a stronger and more deleterious physical effect on older persons. Further, because older persons often take multiple medications, the potential for an interaction between medication and alcohol is higher. Alcoholism can cause symptoms (confusion, disorientation) that can be mistaken for other diseases.

Alcohol dependence in the older population has been estimated at less than 5% of the older population. Most of these are men. Although some of these individuals become alcoholics due to a reaction to aging changes such as widowhood, retirement, or poor health, most have had problems with alcohol for their entire life.

The individual older person should discuss their use and ideas about alcohol with their physician. Physicians and other health

care providers must learn to question and counsel, if necessary, older persons about the extent of their use of alcohol. This should be a part of all patient assessment encounters. Intervention with older persons with alcohol dependence has been shown to have tremendous potential for success. One particular technique, Brief Intervention, can have a significant result on a problem drinker, especially when done by a physician.

CHECK OUT THESE WEBSITE RESOURCES:

The US Department of Agriculture acknowledges the benefits of alcohol consumption: http://tinyurl.com/87t3aot

The Substance Abuse and Mental Health Services Administration of the US Department of Health and Human Services has a variety of information on older adults and alcohol abuse. See the 'Older Adults' link at http://www.samhsa.gov/

Search 'alcohol' on the website of The American Heart Association http://www.heart.org/HEARTORG/

SUGGESTIONS FOR FURTHER RESEARCH

Eidleman, R.S., Vignola, P., Hennekens, C.H. (2002). Alcohol consumption and coronary heart disease: a causal and protective factor. Semin Vasc Med. 2002 Aug;2(3):253-6.

Ira J. Goldberg, I.J., Mosca, L., Piano, M.R., Fisher, E.A. (2001). Wine and Your Heart: A Science Advisory for Healthcare Professionals From the Nutrition Committee, Council on Epidemiology and Prevention, and Council on Cardiovascular Nursing of the American Heart Association Circulation. 2001;103:472.

Oslin DW. (2004). Late-life alcoholism: issues relevant to the geriatric psychiatrist. Am J Geriatr Psychiatry. 2004 Nov-Dec;12(6):571-83.

BUSINESS OPPORTUNITIES

Rehabilitation clinics for older persons with alcohol problems; marketing wine and wineries to baby boomers and older persons.

POLITICAL ISSUES TO WATCH

Continuing struggle between those in favor of moderate alcohol consumption and those concerned about excessive alcohol use or opposed to alcohol on moral grounds. This will play out mostly in those government health agencies that govern advertisements on the benefits of alcohol including wine.

Older persons with the blues

Depression is a health issue of special concern for older persons. Although depression is sometimes perceived as 'normal' for an older person, it is not normal. It is a disease that is treatable. There are a number of reasons this is important: 1) Depression in older persons is often undiagnosed or misdiagnosed. It is sometimes difficult to distinguish from dementia, resulting in inappropriate treatment. In one major study, primary care physicians missed 1/2 of depression in older persons. 2) The consequences of depression for older persons can lead to decrease in physical function, severe health problems, failure to recover from illness, and suicide. 3) The interaction of medications is sometimes associated with depression and the potential of medications as a contributing factor should always be explored.

Fortunately, less than 4% of older persons who live in the community are depressed However, depression among older persons in nursing facilities and other institutions can approach

15%. Estimates of older persons with occasional (normal) depressive symptoms range from 10-25%.

Health professionals, when evaluating an older person for depressive symptoms, should look at changes in mood or perception of self, the older person's perception of the burden of events in their life, including changes in health, changes in daily function, increase in fatigue, diminished interest in life, or feelings of worthlessness. Depression in older men, especially older white men, can lead to suicide. The suicide rate for older white men is double that for other population groups, and, incredibly, 70% have seen a physician in the month before their suicide.

CHECK OUT THESE WEBSITE RESOURCES:

The National Alliance on Mental Illness provides an excellent introduction to depression in older adults:
http://www.nami.org/Content/ContentGroups/Helpline1/Depression_In_Older_Persons.htm

The National Institute of Mental Health:
http://www.nimh.nih.gov/publicat/elderlydepsuicide.cfm

The American Psychological Association:
http://www.apa.org/pi/aging/depression.html

SUGGESTIONS FOR FURTHER RESEARCH

Fiske, A., Wetherell, J.L. & Gatz, M. (2009). Depression in older adults. Annual Review of Clinical Psychology, 5: 363-89.

Hybels CF, Blazer DG. (2003). Epidemiology of late-life mental disorders. Clin Geriatr Med. 2003 Nov;19(4):663-96

Blazer DG. (2003). Depression in late life: review and commentary. J Gerontol A Biol Sci Med Sci. 2003 Mar;58(3):249-65.

BUSINESS OPPORTUNITIES

Psychiatric and counseling services for older persons; pharmaceuticals; complementary and alternative medicine and therapies.

POLITICAL ISSUES TO WATCH

The continued disparity between reimbursement for treatment for physical illness and reimbursement for treatment of mental illness.

Dementia

Dementia is a group of symptoms that includes significant deterioration in cognitive capacity, such as loss of memory, judgment, reasoning, attention and orientation, and a deterioration in the ability to function. It imparts a tremendous burden on the individual and family and friends who support them. Alzheimer's Disease is the most common disorder causing dementia in older people. Alzheimer's disease is not preventable and, except in early stages, is untreatable. The typical victim lives 7-9 years after onset although some can live much longer.

Studies have produced varying estimates of the number of people with some form of dementia. An Alzheimer's Association study suggests that 10 million baby boomers will develop the disease. Firm estimates of the number of people with the disease has proven futile, mostly because of problems defining dementia and different ways to conduct the studies. Diagnosing dementia continues to be a difficult process. A rate of at least 10% of persons over the age of 65 is a good midpoint in the range of estimates. One study of community-based older persons estimates the prevalence of Alzheimer's Disease, including mild symptoms to be 3% for those 65-74, 18.7% for those 75-84, and 47.2% for those over the age of 85.

Only a few drugs are available for treatment of persons in early stages of Alzheimer's disease. However, after a certain point in the progression of the disease, these lose their effectiveness.

The care is a substantial burden for a person with Alzheimer's disease and their caregiver. It can impair the health of the caregiver. The phrase "the 36 hour day" (from the book of the same name by Nancy Mace and Peter Rabins) best describes the overwhelming nature of the burden. The economic cost to the formal long-term care system is substantial and can be devastating for family financial resources. With no effective treatment, the pressure on family caregivers will continue to strain their physical, mental, and financial resources.

CHECK OUT THESE WEBSITE RESOURCES:

The key organization providing information on the disease is the Alzheimer's Association: http://www.alz.org/

See their report on the future impact of Alzheimer's Disease on US health care. (http://www.alz.org/alzheimers_disease_facts_figures.asp)

The National Institute on Aging also has information about the disease and other dementias: http://www.nia.nih.gov/Alzheimers/Publications/adfact.htm

SUGGESTIONS FOR FURTHER RESEARCH

Mace, N.L. & Rabins, P.V. (2006). The 36-Hour Day, (4th Edition). Baltimore: Johns Hopkins University, 2006.

Alzheimer's Association. (2008). The 2008 Alzheimer's Disease Facts and Figures. Retrieved March 20, 2008 from http://www.alz.org/alzheimers_disease_facts_figures.asp

Clark, C.M. & Karlawish, J.H. (2003). Alzheimer disease: current concepts and emerging diagnostic and therapeutic strategies. Ann Intern Med. 2003 Mar 4;138(5):400-10.

Evans, D.A., Funkenstein, H.H., Albert, M.S., Scherr, P.A., Cook, N.R., Chown, M.J., Hebert, L.E., Hennekens, C.H., & Taylor, J.O. (1989). Prevalence of Alzheimer's Disease in a Community Population of Older Persons. JAMA, 262, 2551-2556. (Note: this is a classic study that still provides good estimates of prevalence.)

BUSINESS OPPORTUNITIES

Caregiver support services and products; pharmaceuticals; services to businesses to help them handle the effects of caregiving on employees.

POLITICAL ISSUES TO WATCH

As with all diseases, research into causes and cures is of interest to everyone from the caregivers to pharmaceutical companies. One area to watch is the advocacy on the part of Alzheimer's disease organizations and companies to encourage the Federal government to increase research dollars at the National Institutes of Health for this disease. However, given Federal budget limitations, Alzheimer's disease is only one of a number of diseases calling for more resources. Another political issue connected to dementia and diseases such as Alzheimer's is stem cell research. Expect continuing controversy with those who advocate for research to address incurable diseases aligned against those who oppose the use of stem cells.

What is Long-term care?

Understanding the provision and financing of long-term care is one of the most difficult issues to master for older persons and their families. When a chronic disease impedes the ability of an older person to take care of themselves they will need care over a long period of time. Long-term care includes social, residential and health services for persons who have chronic diseases and disabilities.

In the United States, families and friends provide 75% of the support and services needed. The formal long-term care system provides the rest of the needed services. Such services range from home-delivered meals to hospice and palliative care. Here are the major long-term care services:

- Home and Community-based Services
- Adult Day Care
- Home health Care
- Homemaker/Personal Care
- Social Support Services
- Home-delivered meals
- Transportation
- Residential / Medical Services
- Nursing Facilities
- Sub-acute Care
- Inpatient Hospice
- Residential / Assisted Services
- Board and Care
- Assisted Living
- Continuing Care Retirement Communities

An older person moves through the different levels of long-term care as their functional status changes. Problems with activities such as cooking, cleaning, managing money, telephoning, and shopping would usually necessitate increased assistance on the part of family and friends. When the family cannot provide enough assistance, they would first consider obtaining home and community-based services such as meals delivered to their home. Should the combination of increased informal support and community services prove inadequate, the next step would be to move to an assisted residential care facility, known as assisted living. Finally, when a person begins to have significant

problems with activities of daily living such as dressing, eating, bathing, or toileting they would obtain home health services in the assisted living facility or move to a medical residential facility such as a nursing home.

These services are paid for through various methods. Unlike Medicare for acute illnesses, there is no general financing of long-term care costs. Most people pay privately for long-term care services and they are very expensive. Medicare will pay for rehabilitation services only for a short time following an acute injury. A growing, but still small, percentage of older persons have long-term care insurance. Medicaid pays for about ½ of nursing home care but that is only for people who have no resources and an income that will not cover the costs of their nursing home care or who have depleted their resources. Payment for care in assisted living facilities is all private, directly from the consumer. Some community agencies help with the cost of home and community services, but these also are primarily paid for from private funds.

Because Medicaid is funded by the federal government and state taxes, and because many nursing home residents end up on Medicaid, most states seek to slow nursing home growth through limits (called moratoria) on new nursing home beds and low reimbursement rates. Nursing home care is the most expensive level of care with annual costs ranging from $50,000 to $100,000 per year. Many states are trying to expand the use of less costly alternatives to nursing homes such as home and community-based services and assisted living facilities. Also, most older persons fear moving into a nursing home because they will lose their ability to function autonomously. They fear the quality of care (especially the food), and the reduction in personal choice. However, older persons become eligible for a nursing home because their need for skilled nursing care is so severe that they cannot remain in their home or community; a nursing facility is the only place at which they can receive the necessary care. The quality of nursing home care varies and important reform efforts, such as the Eden Alternative, are underway. The Long-term Care Ombudsman program of the Administration on Aging help individuals around the country to resolve complaints about care in nursing facilities and other institutions.

In the future, expect a rise in the number of persons needing long-term care due to the growing number of older persons. With smaller families, expect a greater reliance on formal, paid long-term care services whether in the home or in a facility.

CHECK OUT THESE WEBSITE RESOURCES:

The Center for Medicare and Medicaid Services site on long-term care:
http://www.medicare.gov/LongTermCare/Static/Home.asp

The Kaiser Family Foundation is a good information source for all health care issues, including long-term care:
http://www.kff.org/

SUGGESTIONS FOR FURTHER RESEARCH

Coleman EA. (2002). Challenges of systems of care for frail older persons: the United States of America experience. Aging Clin Exp Res. 2002 Aug;14(4):233-8.

Palley HA. (2003). Long-term care policy for older Americans: building a continuum of care.J Health Soc Policy. 2003;16(3):7-18

Stone, R.I. (2000). Long-Term Care for the Elderly with Disabilities: Current Policy, Emerging Trends, and Implications for the Twenty-First Century. New York: Milbank Memorial Fund August 2000.
http://www.milbank.org/0008stone/

BUSINESS OPPORTUNITIES

Long-term care services and facility operation; geriatric case management services to assist both local and long-distance caregivers. Counseling about estate planning and protection of resources for one's children/ grandchildren..

POLITICAL ISSUES TO WATCH

With growing numbers of baby boomers responsible for care of aging parents, they may begin to raise the issue of greater societal support for long-term care and concerns about current estate recovery provisions. Controversies between the nursing home industry, the assisted living industry, and home care industry for public support is another controversial area..

Quality of health care

How can the United States, known for the highest quality medical care in the world, still rank lower than many other countries on indicators of health? What is quality? What is quality in health care for older persons?

There are three main issues in judging quality: 1) the quality of the structure of care, i.e., the education and training of the health care providers and their setting and equipment; 2) the quality of what they do, the treatments they use, how they care for older persons (processes of care); and 3) whether what they do makes the older person better or worse (outcomes of care).

The lack of geriatric training of health care providers is the single most detrimental characteristic of US health care for older persons. (See Issue #16.) In addition, too many of their physicians, nurses and other health professionals are trained in the hospital rather than in nursing homes and in home health agencies where older persons will receive the majority of their ongoing care.

The second issue, the quality of treatments and processes of care, is under constant review. New and refined treatment protocols emerge. How closely they are followed is another matter. Our medical system was built on providing care for acute conditions. We do well at this. But now that chronic conditions play a much larger role in health care needs, there is not enough information about what works to improve the functioning of people with chronic conditions. Furthermore, care for chronic conditions often relies on a team-based approach that emphasizes the role of gerontologists, nurses, pharmacists, social workers, and therapists and also family members. New processes of care need to be developed to maximize the use of such teams. We need new treatment protocols on the transitions between care settings, the importance of self-management, how to make lifestyle changes to improve health, and the interaction between physical conditions and social conditions and support.

Attention in recent years has focused on the third issue, the outcomes of care provided. Medicare has set up indicators of quality for hospitals, nursing homes, and home health agencies. Also, one can compare health care plans and Medigap policies and Medicare prescription drug plans. For example, check out the quality indicators for particular nursing homes in a specific geographic area on the Nursing Home Compare website of the Center for Medicare and Medicaid Services (see below). More research is being conducted that looks at how we as patients fare after the medical care is provided.

But other important issues affect quality. The most important one is cost. We know, for example, that to reduce incontinence, systematic toileting of nursing home residents at risk works. But to do so, more staff is required and staff costs money, so often there is not enough staff to do this process of care. Also, access to quality care remains inequitable. Too often minority per-

sons and women do not receive the same treatments and protocols given to white males. These types of health care disparities must be addressed.

Although there has been more and more attention on the quality issues of long term care, there is still more progress to make. Gerontologists must learn to advocate for older persons in a system that has too few resources and too little an understanding of how to provide quality care to older persons.

CHECK OUT THESE WEBSITE RESOURCES:

The Medicare site of the Center for Medicare and Medicaid Services (CMS) provides good information on the quality of health care. Check out the comparisons part of the site: http://www.medicare.gov/

The National Commission for Quality Long-term Care. Although supported in part by members of the long-term care industry, this site provides excellent, objective information on the efforts to improve long-term care quality: http://www.ncqltc.org/reports.html

The Agency for Healthcare Research and Quality has an excellent site on long-term care issues including quality issues to watch: http://www.ahrq.gov/research/ontime.htm

SUGGESTIONS FOR FURTHER RESEARCH

Wunderlich, G.S. & Kohler, P.O. Editors. (2001). Improving the Quality of Long-Term Care. Committee on Improving Quality in Long-term Care, Division of Health Care Services, Institute of Medicine. Washington, D.C.: National Academy Press.

Mor, V. (2005). Improving the quality of long-term care with better information. Milbank Quarterly, 83 (333-364).

BUSINESS OPPORTUNITIES

Consultants to improve care provided by organizations, geriatric care managers to help select appropriate levels of care and monitor ongoing care, software programs to monitor care, geriatric care training programs.

POLITICAL ISSUES TO WATCH

The quality of long-term care will be overwhelmed by the political issue of how to pay for long-term care. With an increase in baby boomers, drains on private resources and Medicaid funds may engender advocacy for a more rational system of support for those who need long-term care. The quality of care delivered in the home will also be under debate as more resources shift away from institutional care settings into home care settings.

End-of-Life Care

End-of-life care is a difficult topic to discuss with older persons and their families. Family and friends do not want to watch their loved one die. Yet, many do not want to make hard decisions about ongoing care. Many health care workers, including physicians, see end-of-life care through a lens of failure and defeat. Society is slowly accepting the concept of a death with dignity over the concept of preservation of life at all costs.

End-of-life care walks along the knife's edge of the individual's soul. At no other point in an older person's life do their personal ethics and beliefs play such an intense role. There are many things to consider when an individual has reached the stage where the end of their life is near. Key questions include: 1) What is the prognosis? 2) What is the mental and physical state of the individual? 3) What health care resources will be brought to bear?

The greatest amount of health care received over a life time occurs at the end of life. The impetus is to keep people alive.

When that is no longer possible, at least not in the way we expect, decisions must be made. These are some of the most important decisions that will ever be made with and for any person.

Care at the end of life is improving, both in the capacity to keep people alive and in ameliorating the pain and depression that can remove any sense of quality of life. Physicians are better educated on managing symptoms. Improved processes of care like hospice care and palliative care are responding to needs to die with dignity. Hospice is a Medicare service for those diagnosed with a terminal illness and with limited time to live. Palliative care services seek not to cure but rather to manage any pain that may come with the life-threatening illness.

The end of life is a difficult time for all. Individuals can help guide their care when their thinking and decision-making capacity is impaired through the use of advance directives. (See next chapter.)

CHECK OUT THESE WEBSITE RESOURCES:

Caring Connections is a program of the National Hospice and Palliative Care Organization (NHPCO), a national consumer engagement initiative to improve care at the end of life: http://www.caringinfo.org/

SUGGESTIONS FOR FURTHER RESEARCH

The Agency for Healthcare Research and Quality issued a report on end-of-life care that is based on the best scientific evidence available: http://www.ahrq.gov/downloads/pub/evidence/pdf/eolcare/eolcare.pdf

Qaseem, A., Snow, V., Shekelle, P., Casey, Jr., D. E., Cross, Jr., J.T. & Owens, D.K. (2008). Evidence-based interventions to improve the palliative care of pain, dyspnea, and depression at the end of life: a clinical practice guideline from the American College of Physicians. Annals of Internal Medicine 15 January 2008 Volume 148 Issue 2, 141-146.

Zimring SD. (2006). Health care decision-making capacity: a legal perspective for long-term care providers. J Am Med Dir Assoc. 2006 Jun;7(5):322-6. Epub 2006 Mar 23.

Kwak J, Haley WE. (2005). Current research findings on end-of-life decision making among racially or ethnically diverse groups. Gerontologist. 2005 Oct;45(5):634-41.

BUSINESS OPPORTUNITIES

Palliative care and hospice services; counseling on end-of-life decision-making; mediator and ethicist services; trainers on palliative care and ethical decision-making.

POLITICAL ISSUES TO WATCH

Euthanasia, in the form of physician-assisted suicide, remains a political issue despite its criminalization in most states. A strong system of palliative care may reduce the impetus of many who are in pain to seek an end to life. Costs and futility of some end-of-life treatments continue to be debated.

End-of-Life Care Advance Directives

Family members and health care workers are usually very involved in end-of-life care. Members of both groups wonder what they should advise, what they should do, and often they end up disagreeing with the course of action taken. What is to be done then? Sometimes society, in the form of the legal authorities, plays a significant role. Most of the time, the burden falls on family. Decisions made around end-of-life can seem to be the most important and difficult ones we will ever make.

People must review their values before they are at the end of life and they must tell their loved ones about their values and their wishes. What do they want to happen when they are at the end of their life? Under what circumstances do they want intervention to continue and what type of care do they think is best? Each answer is as unique as each individual.

For family and close friends, it's important to understand the wishes and values of their loved one. They wonder what they should advise, what they should do, and in the worst of circumstances, end up in disagreement. It's their role, if they are the decision maker about their care, to seek intervention and care that conforms to what their loved ones expressed, even if to do so they must put aside their own values. Most times this will require them to act strongly as advocates in a health care system geared toward preserving life at all costs. They must support their loved one's autonomy by allowing them as much control over their end-of-life decisions as possible. They must keep faith with their loved ones, to fulfill promises to support their wishes.

There are three basic documents that can be prepared to help guide decisions about care. The first is the medical (or durable) power of attorney, a special power of attorney that must be executed before a person loses mental capacity. It assigns another person, usually a very close relative or friend, to make the decisions about their care once the individual can no longer do so for themselves. The second document, often called a living will, sets out what medical procedures and interventions a person wishes to have or not have administered. The final document, an organ donation assignment lets their family and health care providers know whether they wish to make an organ, tissue or eye donation of their body upon their death.

These are difficult decisions. What are the principles you value most? How do these principles affect your own decision making? How do your own values influence how you respond to ethical dilemmas? What do you do when your values are in conflict? These are questions to ask yourself on a regular basis. Write down the answers and discuss them with your family and friends.

We tend to respect a number of ethical values when we become involved with loved ones who are at the end of life. These values are: 1) autonomy – their right to self-determination; 2) beneficence – the desire to bring about the best possible solution; 3) fidelity – the desire to keep faith with our loved ones, to fulfill the promises we have made; 4) justice – to treat the person equitably, fairly; 5) non-maleficence – to refrain from doing harm; and 6) veracity – to tell the truth.

The bottom line is to know as much about your ethical stances as you can and learn the values of people close to you. When these people are at the end of their life, stand up for their values, not yours.

CHECK OUT THESE WEBSITE RESOURCES:

The U.S. National Library of Medicine and the National Institute on Health have information on advance directives: http://www.nlm.nih.gov/medlineplus/advancedirectives.html

SUGGESTIONS FOR FURTHER RESEARCH

Zimring SD. (2006). Health care decision-making capacity: a legal perspective for long-term care providers. J Am Med Dir Assoc. 2006 Jun;7(5):322-6. Epub 2006 Mar 23.

Kwak J, Haley WE. (2005). Current research findings on end-of-life decision making among racially or ethnically diverse groups. Gerontologist. 2005 Oct;45(5):634-41.

McAuley WJ, Buchanan RJ, Travis SS, Wang S, Kim M. (2006). Recent trends in advance directives at nursing home admission and one year after admission. Gerontologist. 2006 Jun;46(3):377-81.

BUSINESS OPPORTUNITIES

Legal advice on advance directives; mediation and counseling on end-of-life decision-making, ethics mediation..

POLITICAL ISSUES TO WATCH

This is a major political issue even after the Terry Schiavo incident where the state of Florida stepped in to oppose the end of life wishes as expressed by the wife to the husband. The issue speaks directly to the right-to-life debate, one of the hottest political issues of our time.

What do health care providers know about aging?

As people age their bodies interact with injury and disease differently. Their metabolism slows a bit. Their range of motion decreases. Their senses lose some of their sensitivity. Their muscles and their lungs decrease in capacity. It's important for health professionals to understand the aging body and how it works with the treatments and medications needed.

Unfortunately, few health care professionals are trained in geriatrics and gerontology. This shortage hurts their capacity to care for a growing aging population. There is a limited supply of geriatricians, nurses and other health care workers with gerontological training. There are only 5 geriatricians for every 10,000 persons over the age of 75. Most medical students do not choose geriatric care. As older physicians, nurses, and other health care professionals retire, they are not being replaced with comparably trained professionals. There were actually fewer geriatricians in 2004 than in 1998.

Only one in ten nursing programs require a course in geriatrics. Few health professionals are interested in working with older persons. It's less lucrative; the reimbursement for a medical visit with an older person often does not cover the cost. It takes

more time to understand the complexity of chronic diseases and aging metabolism. Yet, as the population ages, more older adults will use health care, and thus, more and more health professionals will need to understand how to integrate care of disease with care of an older person.

Without special training, will a health care professional be able to distinguish between dementia and depression, or between dementia and the delusions that could be the result of too many interacting medications? Without an understanding of aging issues, how will a health professional know what is 'normal' aging? As one ages and requires more medical care, they need to find out whether the health care providers they choose are trained in the care of older persons.

CHECK OUT THESE WEBSITE RESOURCES:

American Geriatrics Society site:
http://www.americangeriatrics.org/

Geriatric Education Centers were developed to specifically address these issues and have done so for the past 21 years using strategies of geriatric residencies and fellowships, model curricula, continuing education programs, and clinical geriatrics training. Health Resources and Services Administration site on

SUGGESTIONS FOR FURTHER RESEARCH

Kovner CT, Mezey M, Harrington C. (2002). Who cares for older adults? Workforce implications of an aging society. Health Aff (Millwood). 2002 Sep-Oct;21(5):78-89.

American Geriatrics Society Core Writing Group of the Task Force on the Future of Geriatric Medicine. (2005). Caring for Older Americans: The Future of Geriatric Medicine. JAGS 53:S245–S256, 2005..

BUSINESS OPPORTUNITIES

Geriatric training; health care professional employment search firms; legal actions on behalf of older persons undergoing poor quality care when geriatric trained personnel are not part of the treatment team.

POLITICAL ISSUES TO WATCH

With older health care workers, physicians, nurses, therapists retiring, special programs to train health care providers should increase in value. However, it may be that industry finds more efficient ways to deliver the same level of care. There will be continual disputes between the primary and general care disciplines, such as geriatrics, versus the specialists about reimbursement rates from Medicare.

Health Care Literacy

Health care literacy is “the degree to which individuals have the capacity to obtain, process, and understand basic information and services needed to make appropriate decisions regarding their health.” (Source: Institute of Medicine).

Low health care literacy undermines the quality of health care. People with low health literacy do not obtain important health prevention tests such as mammograms. They do not obtain adequate follow-up care. Some cannot read the labels on prescription bottles nor the instructions sent home after a seeing a physician, a clinic visit or a hospital stay. They may not be able to adequately articulate their symptoms and conditions to a health care provider.

Researchers have shown a connection between low health literacy and negative health outcomes. Health care literacy is not limited to those with low literacy in general. Many people, confronted with the stress of poor health or the crisis of illness can go through stages of low health literacy. They may misunderstand their doctor, misread their prescription or care instructions, or misunderstand visual clues. Also, as the complexity of health care increases, many people need to develop new skills of health literacy. These include the ability to evaluate the credibility of health information obtained on the Internet, the ability to analyze risks and benefits of health care procedures and of insurance plans, the capacity to juggle multiple medications and to understand their care instructions and the results of biomedical tests.

One solution is to make literacy and health education a component of all educational levels from kindergarten to college. English as a second language courses should include health literacy. Outreach must be done to ethnic minorities, older persons, and caregivers of persons with impaired cognitive ability.

CHECK OUT THESE WEBSITE RESOURCES:

The American Medical Association recognizes the importance of health literacy to medical treatment. Search 'health literacy' at: http://www.ama-assn.org/

The Partnership for Clear Health Communication is a national group of organizations that advocates for awareness and solutions to low health literacy. Their website includes three questions that every patient should be able to ask their health care provider: http://www.npsf.org/for-healthcare-professionals/programs/ask-me-3/

See the Institute of Medicine's report, "Health Literacy: A Prescription to End Confusion" (National Academy of Sciences, 2004):http://www.iom.edu/CMS/3775/3827/19723.aspx.

SUGGESTIONS FOR FURTHER RESEARCH

Berkman ND, DeWalt DA, Pignone MP, Sheridan SL, Lohr KN, Lux L, Sutton SF, Swinson T, Bonito AJ. (2004.) Literacy and Health Outcomes. Evidence Report/Technology Assessment No. 87 (Prepared by RTI International-University of North Carolina Evidence-based Practice Center under Contract No. 290-02-0016). AHRQ Publication No. 04-E007-2. Rockville, MD: Agency for Healthcare Research and Quality. January 2004.

BUSINESS OPPORTUNITIES

Translation and graphic design to make health information more understandable such as report cards on health care providers, instruction sheets on medical conditions, websites. Training and consultation on health literacy targeted to various groups.

POLITICAL ISSUES TO WATCH

The debate on where resources should be put – health promotion versus medical care. Educating people about their health can also be placing more responsibility on individuals to maintain health rather than using the resources of the society to create a health-supportive environment. Yet, as the pharmaceutical industry firms well know, educating people about their potential conditions can also create more demand for health care.

Aging versus Anti-Aging

The Anti-Aging movement defies aging. Sometimes it also demeans aging. Aging can be seen solely as a detrimental process, one characterized by decline, decline, and more decline. The perceptions of older ages are usually built upon a confusion of the process of aging with disability and disease. Images of aging we often call up are of individuals whose frailty overwhelms their perceptions of strength, whose changing body represents loss, whose mind may appear to be slow or vacant – the stooped, wrinkled, confused, wandering crone or geezer. Thus, the Anti-Aging movement seeks to slow down or stop the aging process.

But is this image accurate? Of course not! First, it focuses on the relatively small percent of older persons who are in ill-health and frail, not the majority of older persons who are dynamic, active and spry. Second, it ignores the strengths that only experience can bring to an individual – the ability to go calmly into situations filled with turmoil, the capacity to live life as a distinct individual, the resilience to reinvent oneself and to revive one's soul.

The aging of an individual creates an environment where the creative impulse and spiritual quest can merge to more deeply connect an individual to life. Anti-Aging can deny the maturity needed to become fully human. Few people wish that their minds would stay as unformed and rickety as minds generally are throughout a person's early years. Yet we desire a body and appearance that more closely resembles those years.

In a narrow sense, the Anti-Aging movement seeks to preserve that youthful appearance and vigor. According to Dr. Ron Klatz of the American Academy of Anti-Aging Medicine, Anti-Aging medicine is a medical specialty founded on the application of advanced scientific and medical technologies for the early detection, prevention, treatment, and reversal of age-related dysfunction, disorders, and diseases. The Anti-Aging movement deems that the ravages of aging disease are not a function of aging and that the processes that cause detrimental aging can be ameliorated or eliminated. Skin, through rejuvenating products, will retain its youthful glow and firmness; drugs can maintain functions that hormones have begun to restrain; and exercise and proper diet can restore the vitality of youth.

From a larger perspective, many of the movement's recommendations are the same sound advice that is given to reduce disease in all populations – exercise regularly, eat appropriately, do not let the sun ravage skin. These activities are the best anti-aging and the best aging well prescriptions.

Thus, a celebration of aging, with all its physical and mental changes is best accomplished by not focusing on anti-aging

techniques but rather on living well actions. The union of physical fitness, emotional maturity, spiritual awareness, and creative thought can only be achieved through aging well.

CHECK OUT THESE WEBSITE RESOURCES:

The home of the American Academy of Anti-Aging Medicine: http://www.worldhealth.net/

SUGGESTIONS FOR FURTHER RESEARCH

Nakasato YR, Carnes BA. (2006). Health promotion in older adults. Promoting successful aging in primary care settings. Geriatrics. 2006 Apr;61(4):27-31.

Rowe JW, Kahn RL. (1997). Successful aging. Gerontologist. 1997 Aug;37(4):433-40.

Depp, C.A. & Jeste, D.V. (2006). Definitions and predictors of successful aging: a comprehensive review of larger quantitative studies. Am J Geriatr Psychiatry. 2006 Jan;14(1):6-20.

Peel NM, McClure RJ, Bartlett HP. (2005). Behavioral determinants of healthy aging. Am J Prev Med. 2005 Apr;28(3):298-304.

BUSINESS OPPORTUNITIES

Anti-aging products and services remain very attractive in a youth culture: any product or service addressing slimness, social activities; improved sex life; improved appearance; stress reduction; mental stimulation. Also sleep assessment and therapy; vitamins, health care screening; tobacco use prevention; and, of course, exercise and nutrition.

POLITICAL ISSUES TO WATCH

Competition between traditional geriatric health care providers and anti-aging health care providers over what is reimbursable care through government and insurance programs. The inherent ageism and anti-aging focus embedded in social policies.

Financial Issues

Goodbye Defined Benefits, Hello Defined Contributions

The baby boom generation was taught that retirement pensions and Social Security would lead to a good old age. Extensive medical benefits would cover our health care needs at almost no cost. They didn't think they needed to do much except get a job with a decent company and all of this would be theirs. Guess what? It was never true for most people and it's less true now.

In terms of sources of retirement income we have moved from defined benefits to defined contributions. A defined benefit is a specific amount of retirement income based on salary or years of service to the company. With a pension, when a worker retires, the employer pays a monthly amount for the rest of the worker's life. If the individual lives to be 100 with a pension, the pension amount will still be paid. (If you worked there a long time, if your employer stays in business… oh, there are conditions).

Defined contributions are when the worker contributes money (sometimes with some matching money from the employer) to a retirement plan that is owned by the worker. It is this fund that will support the person's retirement. Once an individual retires from the company, that firm is not involved with paying for the individual's retirement. These are usually known as 401(k) accounts. The worker makes the decisions about how to save for retirement in their private account and determines how to invest it and, upon retirement, how to spend it.

How does this differ from a pension? In a defined contribution plan, a 401(k) plan, the employer may help fund the plan. When the retiree leaves the employment they take the money with them. The company has no further responsibility toward the retiree. If the worker has accumulated $100,000 in their retirement plan, that's what they live on in retirement, or if they've accumulated $1,000,000, that's what they live on.

CHECK OUT THESE WEBSITE RESOURCES:

The US Department of Labor has a rich website on this issue: http://www.dol.gov/dol/topic/retirement/typesofplans.htm

If you are interested in the applicability of the defined contributions model to health care benefits, see this site from the Center for Studying of Health System Change: http://www.hschange.com/CONTENT/273/

To explore definitions of 401(k) plans and pensions and related financial aspects of retirement, see: http://www.investopedia.com/terms/d/definedcontributionplan.asp

SUGGESTIONS FOR FURTHER RESEARCH

Craig, C.K. & Toolson, R.B. (2008). Retirement Plan Options for Public University Faculty-The High Cost of a Wrong Choice Journal of Deferred Compensation. Spring 2008. Vol. 13, Iss. 3; p. 36-66. This article is a good introduction to the advantages of the two types of retirement plans.

Ezra, D. (2007). Defined-Benefit and Defined-Contribution Plans of the Future. Financial Analysts Journal. Jan/Feb 2007. Vol. 63, Iss. 1; p. 26 (6 pages)

BUSINESS OPPORTUNITIES

Investment firms to manage growing 401(k) plans. Personal investment advisors to assist individuals to manage their savings and the retirement drawdowns. Insurance products such as annuities to change 401(k) assets into guaranteed income.

POLITICAL ISSUES TO WATCH

As firms come under increasing fiscal pressure, they may terminate or reduce their pension liabilities and responsibilities. However, this will have a devastating impact on retirees. Expect more pressure for government intervention to bail out such pension programs. The adoption of the defined contributions mode to health care benefits is also generating controversy.

Count on Social Security.

Social Security is not ‘bankrupt’. You can count on it. Social Security is the support society gives to older persons. It’s an acknowledgement that older persons have worked hard and done the best they could for society and so they deserve support when they no longer work. It is also a way for society to open up job opportunities for younger workers. It’s a societal compact between generations and public support for it remains strong.

Social Security supports payments to older workers from two sources. The first is a trust fund that has built up value based on the large contributions of all workers and there was money left over in excess of the payments out to Social Security recipients. The surplus is put in a trust fund for future use. The second source is the ongoing contributions from current workers via their Social Security deductions. Future workers are then expected to pay contributions into Social Security for them.

There are three parts of Social Security. The first is the retirement support in old age, or old age insurance, as described above. The second is disability insurance. If a worker becomes disabled and cannot work, they are entitled to disability payments under Social Security. The third part is life insurance, called survivors’ benefits; if a worker dies, payments can be made to the person’s widow and children (until they are 18 years of age).

Retirement benefits are calculated based on the lifetime earnings of the worker (although there is a cap on contributions for high incomes). To qualify, a worker must have paid into the So-

cial Security system for 40 quarters of work.The longer one works and the higher the income, the higher the Social Security payment. The maximum payment in 2011 is about $2500, and the average payment is about $1200. There is no minimum payment.

Retirement benefits can begin as early as age 62. However, at age 62, the benefits are reduced and equal to about 75% of the full benefits that could be paid to the worker. The current retirement age is gradually increasing from age 65 to age 67. For people born after 1943 it is 66 years of age, and for those born after 1960 it is 67 years of age. Full benefits would not be paid for retirement until a retiree reaches these ages.

Social Security benefits provide the majority of retirement income for 60% of older persons. For 20% of older persons, Social Security accounts for 80% of their income.

When Social Security began there were many workers for every retiree. The older population is growing from about 6% of the population in 1940 to about 20% of the population in 2040. Thus, there are more older retirees in need of support by fewer workers. This leads to concerns over the viability of the Social Security system and calls for reform. Some call for the privatization of Social Security so that the government would not be involved in an individual's retirement. Others call for reform of Social Security to ensure that future retirees will receive full payments. Reform options include raising the retirement age, reducing the benefits, or increasing the level of Social Security contributions. The soundness of the system will depend on politics, not its known strength.

CHECK OUT THESE WEBSITE RESOURCES:

The Social Security Administration: http://ssa.gov/

SUGGESTIONS FOR FURTHER RESEARCH

Rose, R.R. & Cartwright, W. (2009). Social security and privatization: a viable combination? Journal of Comparative Social Welfare, Vol. 23 (1) 2009. p17-25, 9p

BUSINESS OPPORTUNITIES

Financial planning; investments; insurance; Social Security disability advocacy.

POLITICAL ISSUES TO WATCH

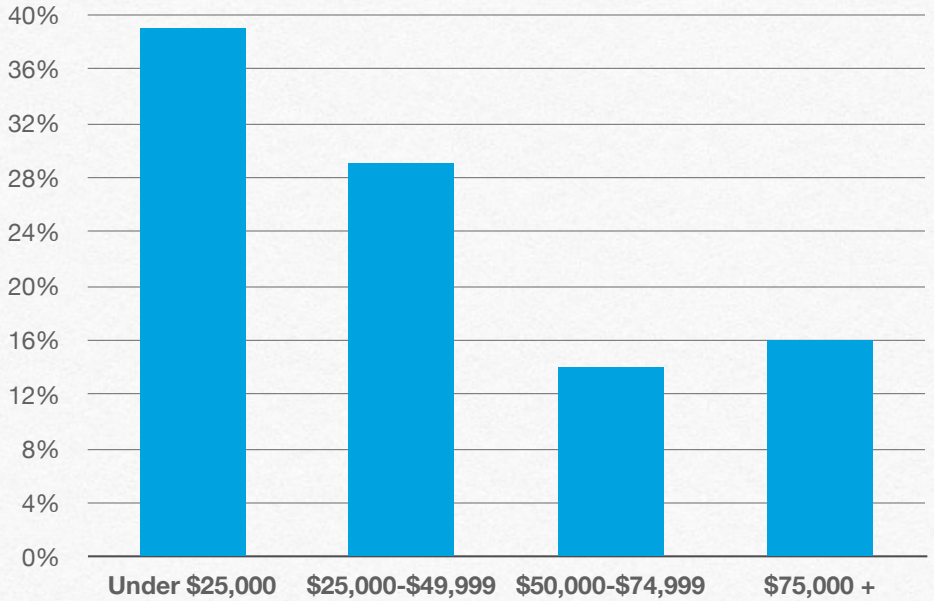
The future of Social Security. The adequacy of Social Security will be a major issue for the large percentage of coming retirees who rely on it for the majority of their income. Any threat or shortfall in benefits would cause major political problems.

But don't count on just Social Security

Social Security was never designed to be the only source of income in retirement. It was designed to prevent poverty in older persons without adequate support available to them. It was envisioned as one leg of a three-legged stool that would support persons after they retired. No one ever expected a person to live well on Social Security alone. The other two legs are income from pensions or retirement savings and income from assets. The important message for future retirees is to think beyond Social Security and take control of their retirement.

The second leg of the stool has been pensions. Although some pensions remain, this source of retirement income has now evolved into what are called 401(k)s. (See Issue 19.) These are retirement savings vehicles based on a partnership between worker and employer. The individual worker contributes part of their income into a 401(k) and the employer, sometimes, matches part of that income with an additional contribution. When the employee leaves the organization, the 401(k) moves along with the employee, or, if retired, is the source of retirement income. An employee also might put savings into a retirement vehicle such as an IRA, an Individual Retirement Account.

Money Income of Households 65 Years and Older Source: U.S. Census, 2009



These savings are not tied to employment at a specific company.

The third leg of the stool is assets and other savings. These may include emergency savings and assets such as a home or rental property.

Last, there are recommendations for a new fourth leg on the stool (making it a chair) – savings for medical expenses. Once retired, these may come out of retirement income. Even with Medicare, the amount the individual must pay out for medical care is rising so fast that this may need to be considered as its own separate savings line. The money would be used to pur-

chase health insurance supplemental to Medicare, to pay for out-of-pocket expenses, and to fund long-term care insurance.

The sooner planning for retirement begins, the better the retirement.

CHECK OUT THESE WEBSITE RESOURCES:

Vanguard Retirement Planner. A good free educational site about financial planning: https://personal.vanguard.com/us/planningeducation/retirement

AARP has a good retirement calculator also: http://www.aarp.org/money/financial_planning/sessionseven/retirement_planning_calculator.html

And a great site on retirement research is Boston College's Center for Retirement Research at http://www.bc.edu/centers/crr/

Motley Fool has a series of financial calculators: http://www.fool.com/

SUGGESTIONS FOR FURTHER RESEARCH

Skinner, J. (2007). Are You Sure You're Saving Enough for Retirement? The Journal of Economic Perspectives. Vol. 21, 3; pg. 2ff.

Madrian, B., Mitchell, O.S. & Soldo, B.J., Eds. (2007). Redefining Retirement: How Will Boomers Fare? Oxford University Press.

Bach, D. (2007). Start Late, Finish Rich: a No-Fail Plan for Achieving Financial Freedom at Any Age. Bantam Dell Pub Group.

BUSINESS OPPORTUNITIES

A growing financial planning industry from large Wall Street firms to individual financial planners seeks to advise and invest the considerable wealth that is accumulating for coming retirees, including investments and conversion of home equity into income streams.

POLITICAL ISSUES TO WATCH

Any perceived large fraud or mismanagement in the major retirement funds would cause political action. There will continue to be doomsday prophets that portray Social Security as failing and monies running out. Tensions between generations as more older persons draw from Social Security and current workers perceive their role as contributors to be stressful.

Challenges to retirement savings.

A consideration of retirement savings in society includes pensions, 401(k) savings, and assets. Although it appears that baby boomers are generally on track for a decent retirement, many will see significant challenges.

Pensions and retiree health care benefits are eroding. Fewer companies and organizations provide pensions and health benefits after working. Many are converting to 401(k) options rather than pensions. Of those that provide pensions, many are renegotiating the agreements to decrease such payouts. And, finally, some companies and governmental entities face such pressure on their finances, especially through bankruptcy, that they may renege on pension and retiree benefit commitments. With these threats, it makes sense for the employee to take control of their own retirement through IRAs and 401(k)s where available.

A second challenge is the adequate funding of 401(k) plans and assets by the employee. Some estimates suggest that about one-half of baby boomers, the next group to retire, have adequate savings. This still places up to 50% of baby boomers at risk of an inadequate retirement. Baby boomers would have to put an additional 3-6% of their income away annually to fund an adequate retirement. Much depends upon the amount of their retirement income needs, the performance of their investments, and the future of Social Security.

A third challenge is the need for workers to proactively manage their retirement planning and investments. They must manage how much to contribute, how to invest these savings and, eventually, how to manage their withdrawals for retirement.

A fourth challenge is the vagaries of the economic system. The recent recession destroyed not only retirement savings but also home equity. Rates of return on investments of any kind are impossible to predict. Historical rates suggest that the prudent investor will not assume too high of an expected return. Inflation, recently under control, is, nevertheless, a potential threat to investments.

Finally, personal crises, such as extended unemployment, caregiving costs, disability, can also result in the need to draw down from retirement savings. Although sometimes unavoidable, a withdrawal for these types of issues needs to be replaced later or a much poorer retirement is in order.

CHECK OUT THESE WEBSITE RESOURCES:

Same ones recommended in Issue 19 but look on the various sites that help determine the best mix of investments. Again, the Motley Fool site offers a balanced look at the options open to you: http://www.fool.com/

SUGGESTIONS FOR FURTHER RESEARCH

Bach, D. (2003). The Automatic Millionaire: A Powerful One-Step Plan to Live and Finish Rich. Broadway Books.

BUSINESS OPPORTUNITIES

Again, financial planning services will be in demand. Real estate assistance for older persons when they are ready to downsize or establish home equity conversions for income. Economic analysis geared to near retirees and older persons.

POLITICAL ISSUES TO WATCH

Increasing demands for public assistance programs if the retirement savings are not adequate for large numbers of people. Government guarantee of pension benefits and retiree health benefits.

Sorry gals. Poverty – thy name is woman.

“Many women are only a man away from poverty.”

Carroll Estes, gerontologist.

The problem of poverty in the older population in the US is largely a problem of older widows. Twice as many older women live in poverty as older men. Our increasing life expectancy explains some of this. Older women outlive their assets and income. Over their lifetime, women, due to their childbearing years and the discriminatory wage structure, earn less money. So even if they have their own funds and retirement support, these are often less than a man’s. In the traditional family structure, the man has served as the major wage earner with the woman as the secondary earner. Therefore, the wife’s retirement income is a product of their husband’s lifetime earnings. A woman’s average pension has been about 1/3 less than the average pension of a man.

By age 85 three of four women are widows. In the more traditional pension plans, when the man died, the pension was terminated, drastically reducing the older women’s income.

Also, compared to men, older women are less likely to remarry, and so they do not become a part of a two-income household again. Among older women generally, about one-third rely on Social Security for 90% of their income. Minority women carry a double risk; over one-half of unmarried African-American and Latino women have only Social Security to support them. These Social Security benefits are not enough to raise them above the poverty level.

Many women experience periods of poverty throughout their life and thus their retirement income is adversely affected. Lower education, having many children, and absence from the labor market for substantial periods will make for a poor retirement. Social Security benefit levels are determined based upon earnings over a long period of years. Less earnings and absence from the workforce reduces the amount of the Social Security benefit. Also fewer women than men have had the opportunity to participate in pension plans. In 2004, per the U.S. Department of Labor, the median income for women over the age of 65 was $12,080 while the median income for an older man was almost double that amount.

The most important program for older persons of very low income is SSI, the Supplemental Security Income program. Support is available for older and disabled persons who meet strict low income and low resource limits. Although administered by the Social Security offices, the program is funded through general revenue and not Social Security funds.

CHECK OUT THESE WEBSITE RESOURCES:

Department of Labor Women's Bureau:
http://www.dol.gov/wb/factsheets/Qf-olderworkers55.htm

The Older Women's League is a national grassroots membership organization focusing solely on issues unique to women as they age. OWL strives to improve the status and quality of life of midlife and older women:
http://www.owl-national.org/pages/issues-economic-security

AARP is a good source on the topic - search 'women and poverty' at: http://www.aarp.org/

SUGGESTIONS FOR FURTHER RESEARCH

Richard V. Burkhauser, Philip Giles, Dean R. Lillard, and Johannes Schwarze.(2005.) Until Death Do Us Part: An Analysis of the Economic Well-Being of Widows in Four Countries. J Gerontol B Psychol Sci Soc Sci 2005 60: S238-S246.

Even, W.E. & MacPherson, D.A. (2004). When will the Gender Gap in Retirement Income Narrow? Southern Economic Journal. Jul 2004. Vol. 71, Iss. 1; p. 182.

Bodnar, J. ((2003). Think Single: The Woman's Guide to Financial Security at Every Stage of Life (Paperback) Chicago: Dearborn Trade Publishers.

BUSINESS OPPORTUNITIES

New housing options for older women with low incomes; dating and matchmaker services; employment support for low-income older women; legal services for women with husbands about to retire.

POLITICAL ISSUES TO WATCH

Pay equity and non-discrimination of women; generational conflict over children’s poverty rate versus older person’s poverty rate.

The best health care in the world – if you got the bucks.

How do we pay for health care for older persons in the US?

First, there's Medicare, the program for persons with disabilities and those who are over the age of 65. Some older persons have joined Medicare HMOs where they receive extra care at a reduced cost.

Second, many older persons pay privately for supplemental medical care coverage, usually called Medigap insurance. This insurance helps cover the cost of co-pays, deductibles and some prescription drugs.

Third, private funds are a source of payment in the form of co-pays, deductibles and full payment by older persons for some procedures. As health care becomes more expensive, government programs, employers and insurers will shift more and more of the costs to the individual. From higher co-pays to consumer directed health plans, the individual will take on more personal responsibility for paying for their own health care.

It's been estimated that a couple over 65, even in good health, would need an extra $200,000 in retirement savings just to cover Medicare premiums, co-pays and deductibles and other health care expenses.

Over 20 percent of families headed by people 55 to 64 and more than 50 percent of the families headed by people over 65 pay over 10 percent of their income on health care, when out-of-pocket costs and premiums they pay directly are included. The average out-of-pocket cost for Medicare beneficiaries over the age of 65 exceeds $2,400. (Expenses included Medicare deductibles, coinsurance, services not covered, dental care, prescriptions, Medicare Part B, private insurance, and Medicare + choice.)

The more we shift to individual responsibility, and require greater copays and greater deductibles, the higher the impact on those with middle and lower incomes. Annual out-of-pocket expenditures for health varied from 9 percent for the high income group to 16 percent of total health care expenditures for the middle income group and 13 percent for the low income group. The older the person, the more they'll end up paying for health care as they struggle against diseases and chronic conditions.

CHECK OUT THESE WEBSITE RESOURCES:

National Coalition on Health Care: http://www.nchc.org/

Kaiser Family Foundation:http://www.kff.org/

SUGGESTIONS FOR FURTHER RESEARCH

Jonas, S. & Kovner, A.R. (Editors). (2005). Health Care Delivery In The United States. New York: Springer Publishing Company, 2005.)

Nonnemaker, L. & Sinclair, S.A. (2009). Out-of-Pocket Spending on Health Care by Medicare Beneficiaries Age 65 and Older, Insight on the Issues, June 30, 2009. AARP Public Policy Institute.

BUSINESS OPPORTUNITIES

Supplemental insurance market should thrive; assisting older persons to maximize their reimbursement through the myriad of available programs; consulting to companies on how to reduce health care expenditures for retirees.

POLITICAL ISSUES TO WATCH

We've already seen substantial progress on prescription drug costs through Medicare Part D. The increase in Medicare costs is a part of the national budget deficit debate. Expect the Affordable Care Act or some such health care reform for older persons and all Americans to be a persistent issue over the next decade.

Medicare – the health care expenses safety net – slowly unraveling.

Medicare is the most important way we cover the acute medical care needs of older people and people with severe disabilities. Who does Medicare cover? Mecicare covers people age 65 or older, people under age 65 with certain disabilities, and people of all ages with permanent kidney failure.

Learn the basic “Parts” of Medicare. Part A is medical insurance, also called Hospital Insurance, for in-patient hospital care and some types of rehabilitation care. Part B covers most doctors’ services, outpatient care and some therapy and home care services and equipment. The newest part, Part D, covers some prescription drug costs. A monthly premium is charged for Part B and Part D. (Are you wondering what happened to Part C? It is the “Medicare Advantage” program and sets up optional managed care plans for people on Medicare.)

We pay for Medicare through payroll taxes, similar to how we pay for Social Security. People pay into Medicare out of their payroll throughout their lives. Current workers pay for current

Medicare recipients. Persons on Medicare pay a monthly premium for Medicare Part B and for Part D. Medicare also relies on federal general fund taxes for support.

Medicare is the second largest domestic program of the Federal Government (after Social Security). Medicare spends an average of over $8000 per person per year on its 41 million beneficiaries, although 26% of all Medicare’s funds are spent for the last year of life.

The deficit in the Medicare program is substantial. That deficit is paid out of the trust fund Medicare has accumulated, but the trust fund reserves are estimated to run out in 2020. So Medicare, like Social Security, will need some attention.

Watson Wyatt Worldwide, a premier financial management consulting firm, states: “Retirees will have to assume greater responsibility in planning and paying for their medical costs in retirement, including saving more, delaying retirement or both.”

Out-of-pocket expenditures for persons on Medicare average over $2000 per year. As more costs are shifted to the individual during working years, Medicare will follow and a great share of the expenditures will be the responsibility of the individual.

Furthermore, with annual growth in health care expenditures at 6-10% per year, older persons can expect substantially increased costs for health care in retirement.

CHECK OUT THESE WEBSITE RESOURCES:

Center for Medicare and Medicaid Services:
http://www.cms.hhs.gov

National Committee to Preserve Social Security and Medicare:
http://www.ncpssm.org/

SUGGESTIONS FOR FURTHER RESEARCH

Newhouse, J. P. (2004). Financing Medicare in the Next Administration. The New England Journal of Medicine, Vol 352:1714-1716.

Watson Wyatt Worldwide. (2002). Retiree Health Benefits: Time to Resuscitate? (http://www.watsonwyatt.com/us/pubs/insider/showarticle.asp?ArticleID=10403)

BUSINESS OPPORTUNITIES

Assisting older persons to maximize coverage and reimbursement for medical expenses through medical insurance sales and management, financial planning elements of care management; generic drug development, low-cost alternatives to formal health care.

POLITICAL ISSUES TO WATCH

With baby boomers struggling to put enough money into retirement to handle their living expenses, it's doubtful they will have the extra that will be needed to handle medical expenses. Expect continuing political debates on how much of retiree's health care should be covered by the Federal government. The viability of Medicare is under debate.

Medicaid – mostly for older people and persons with disabilities.

Who really uses Medicaid services and dollars? – it's not low-income mothers and children. Rather, it's older persons and persons with disabilities. The one-quarter of those on Medicaid who are older and disabled (28%) use almost three-quarters (72%) of the Medicaid dollars. It's even more if we only look at Medicaid prescription drug spending. Eighty percent (80%) of Medicaid Rx spending is for older persons, persons with disabilities, and the chronically ill – and these are 27% of Medicaid enrollees. Only 20% of spending is for mothers and children.

Medicaid was created by Title XIX of the Social Security Act (SSA) of 1965. It is a Federal-State health insurance program for persons with low incomes or persons whose health care costs make them qualify as low-income. It serves all children under 19, pregnant women whose household incomes are at or below the federal poverty level, most SSI recipients, individuals receiving assistance for adoption or foster care under Title IV of the SSA, and some Medicare recipients. Medicaid must provide certain basic services mandated by the federal government. These include inpatient and outpatient hospital services, physician services, nursing facilities for people over 21, rural health clinic services, home healthcare, lab and x-ray, pediatrics, family nurse practitioner services, health centers, and ambulatory services.

The program is administered by the Centers for Medicare and Medicaid Services, a unit of the Department of Health and Human Services of the US Government. Go to the CMS website to review the basics of the Medicaid program including who is covered under what eligibility categories, and what basic services the program covers.

Medicaid has become the major source of payment for long-term health care for older persons and persons with disabilities. Many older persons and persons with disabilities who reside in nursing facilities rely on Medicaid to assist them to pay for needed care. Here's an example of how it works for older persons. Let's say an older person has $2000 per month in income from Social Security and other sources. They are not eligible for Medicaid. But when their health care expenses rise on a permanent basis, such as when they enter a nursing facility for the long-term, they would have to spend all that income on medical care and still do not have enough to cover their expenses. Therefore, they are now low-income enough to qualify for Medicaid.

CHECK OUT THESE WEBSITE RESOURCES:

The Centers for Medicare and Medicaid Services (CMS) is the best source of up-to-date information on both programs: http://www.cms.gov/

These slides give an in-depth understanding of the Medicaid program: http://www.cms.gov/charts/default.asp

Each individual state runs their Medicaid program a little differently. For the Virginia program: http://www.dss.virginia.gov/benefit/medical_assistance/index.cgil

Another excellent source of information about Medicaid is the Kaiser Family Foundation: http://www.kff.org/medicaid/index.cfm

For a nice, brief discussion of the key issues facing the Medicaid program see the testimony of Diane Rowland, Sc.D., Executive Vice President, The Henry J. Kaiser Family Foundation, and Executive Director Kaiser Commission on Medicaid and the Uninsured: http://www.kff.org/medicaid/4146.cfm

SUGGESTIONS FOR FURTHER RESEARCH

Kronick, R., Rousseau, D. (2007). Is Medicaid sustainable? Spending projections for the program's second forty years. Health Aff (Millwood). Mar-Apr;26(2):w271-87.

Miller, E. A. (2005). Medicaid nursing facility reimbursement in flux: effects of federal regulatory changes and prevailing fiscal conditions, 1978-1998. Journal of Aging Policy, 17(2):41-65.)

BUSINESS OPPORTUNITIES

Financial case management for families of individuals who need health care services and are close to the Medicaid level; consulting with state Medicaid programs on design and evaluation of Medicaid programs for older persons; managed care for Medicaid recipients; accounting and consulting services for vendors and health care providers involved with the Medicaid program.

POLITICAL ISSUES TO WATCH

As a federal–state program both levels of government have incentives to shift costs to the other level. Watch for how Medicare and Medicaid come together. New health care plans should involve some redefinition of the use of the Medicaid program as a safety net for the poor and medically needy. Medicaid continues to be one of the highest expense categories in state budgets and legislative sessions seek to limit the costs of the program while advocates stress the need for increased coverage of individuals and for health care services and products. Expect Federal retrenchment on participation in the Medicaid program.

How do we pay for long-term health care?

Long-term care begins when a person can't take care of themselves. Long-term care illnesses by definition, last a long time. They are chronic illnesses or disabilities that are expected to last more than three months. The Congressional Budget office defines long term care as "the medical, social, personal care, and supportive services needed by people who have lost some capacity for self-care because of a chronic illness or condition." Long-term care can occur in a nursing facility, an assisted living facility, or in the home.

Who receives long-term care? Researchers estimate that about 2% of those under 65 use long-term care (3.3 million people). About 17 percent, or about 5.6 million people, over the age of 65 use long-term care. So about two-thirds of long-term health care is for older disabled persons and 1/3 for younger disabled persons.

Who covers long-term care? Two sources pay for almost all long-term care services – the individual's private resources and, as noted above, Medicaid. Medicaid, however, only covers a person once they are at poverty level, having used up all their assets and income to pay for medical care.

Medicare will not cover your long-term care expenses. Read my lips: Medicare will not cover your long-term care expenses. Medicare covers therapy after a hospitalization, even if that ther-

apy occurs in a long-term care facility like a nursing home. Let me say it one more time: Medicare will NOT cover your long-term care expenses.

Here's how it often works. Your Aunt Abby, who lives alone, has a severe stroke and can't look after herself anymore. For a while she may be able to get long-term care services in her community from family and friends and by paying for home care. But, eventually she needs a nursing home with a cost of $60,000+ per year. She can't afford that. She lives on a small pension and Social Security. Most of her wealth is in her home. So she sells her house for, say $240,000, and she can pay for the nursing home for four years. After the four years she still needs care and the nursing home social worker gets her on Medicaid because Aunt Abby can't pay her nursing home bill. (And neither can her family pay out $60,000 per year.)

From then on, Medicaid pays the bill. But Medicaid doesn't pay the nursing facilities as much for the care as Aunt Abby did from her private funds, so Aunt Abby is not such a financially valuable patients when she's on Medicaid. Most would continue to care for her, but some will reduce the level of her care. She may have to move from a private room to a semi-private room. Some may not accept her back if she is hospitalized.

So, if possible, it's important to save enough, on top of retirement in order to handle long-term care expenses.

A second option is the growing choice of long-term care insurance policies. The policies are improving. It's hard to craft a policy that will hold up over the course of 30-plus years in terms of benefits and appropriate cost. Each person's circumstances are different. People with large supportive families may not need a formal long-term care insurance policy. But a single woman, given a long life expectancy, who does not anticipate having children and who has no extended family, should consider some kind of insurance arrangement for formal long-term care.

The time to plan for these expenditures is sooner rather than later.

CHECK OUT THESE WEBSITE RESOURCES:

Again, the Centers for Medicare and Medicaid Services (CMS) has an excellent site on long-term care:
http://www.medicare.gov/longtermcare/static/home.asp

The US Department of Health and Human Services also has an informative site:
http://www.longtermcare.gov/LTC/Main_Site/index.aspx

The National Clearinghouse of the U.S. Department of Health and Human Services:
http://www.longtermcare.gov/LTC/Main_Site/Paying/index.aspx

SUGGESTIONS FOR FURTHER RESEARCH

Focusing on the quality of long-term care but filled with information about the issue is: Wunderlich, G.S., & Kohler, P.O. (Eds.). (2001). Improving the Quality of Long-Term Care, Committee on Improving Quality in Long-Term Care, Division of Health Care Services, Institute of Medicine.

BUSINESS OPPORTUNITIES

Financial case management for families of individuals who need long-term care services; consulting with state Medicaid programs on design and evaluation of Medicaid programs for older persons; accounting and consulting services for vendors and health care providers involved with long-term care; sales and marketing for long-term care products, services and insurance.

POLITICAL ISSUES TO WATCH

The CLASS Act, a voluntary national program of long-term care insurance, was a part of the Affordable Care Act. It will not be implemented due to costs. Medicaid is a federal–state program and both levels of government have incentives to shift costs to the other level. Watch for how Medicare and Medicaid come together. Medicaid, and its payments for long-term care, continues to be one of the highest expense categories in State budgets and legislative sessions seek to limit the costs of the program while advocates stress the need for increased coverage of individuals and long-term care services and products. Expect some conflict between those espousing institutional care and those who favor community-based long-term care.

Social Issues

The new rainbow: What is diversity

All old people are pretty much the same, right? Wrong.

The older a person gets, the more distinct he or she becomes. Individuality comes with age not youth. Life experiences send us all on different paths and elders are more diverse than ever. In what ways are elders diverse?

Age – The term 'older person' often includes people between the ages of 65 and 100 years of age. It's hard to generalize about such a wide group of people. It would be like summarizing people who are 1 year old to 35 years old. Also, chronological age is not a good marker of age. Some 65 year olds act 80, and some 80 year olds have the vitality of 60 year olds.

Race and Ethnicity – Just like the rest of society, the older population is now made up of people from many different cultures. In the next few decades this diversity will increase. Although most older persons are 'white' or 'caucasian', the proportion varies across the country. Besides 'race' does not capture the incredible diversity of ethnic groups within each of the racial categories.

Gender –There is an increasing diversity of gender identities. Although in some segments of the society, the traditional view of gender and role is loosening, considerable discrimination occurs towards lesbian, gay, transgender and bisexual elders.

Other types of diversity in the older population include:

- Education
- Family structure/ Marital status
- Income/Wealth
- Physical abilities
- Religious/Spiritual beliefs
- Sexual orientation
- Work/ Employment

It's increasingly difficult to make statements about "the elderly", or "the older population", but due to this wonderful, new diversity, the richness of older people in the society is enhanced.

CHECK OUT THESE WEBSITE RESOURCES:

Stanford University's Geriatric Education Center's excellent resource on ethnicity and aging:
http://www.stanford.edu/group/ethnoger/

An example of a website for issues of importance to older persons for one ethnic group is the Centro Gerontologico Latino:http://www.gerolatino.org/lead1.html

SUGGESTIONS FOR FURTHER RESEARCH

Gallant, M.P., Spitze, G., & Grove, J. (2010). Chronic illness self-care and the family lives of older adults: A synthetic review across four ethnic groups. Journal of Cross-Cultural Gerontology, 25, (1), 21-43.

Pinquart, M. & Sorensen, S. (2005). Ethnic differences in stressors, resources, and psychological outcomes of family caregiving: a meta-analysis. Gerontologist. 2005 Feb;45(1):90-106.

Trask, B. S., Hepp, B. W., Settles, B., Shabo, L. (2009). Culturally Diverse Elders and Their Families: Examining the Need for Culturally Competent Services. Journal of Comparative Family Studies, Spring 2009, Vol. 40 Issue 2.

BUSINESS OPPORTUNITIES

In the future, there will be a substantial rise in what's called 'cultural competence', the ability to work (and play) effectively with many more people from many different cultures. Services and products will have to be delivered in multiple languages. Some aging services organizations already offer translation services in over 100 languages. Workers in all sectors will need training.

POLITICAL ISSUES TO WATCH

Immigration is part of the national debate and the society needs immigrant workers who pay into Social Security and Medicare. Also, immigrant workers serve as care providers in acute health care and long-term care settings. Health disparities issues: Minority groups, including women, often receive lower quality health care. Gay marriage: Lesbian, Gay, Bisexual and transgender older persons confront ongoing difficulties as they age and are prohibited from entering formal marriages.

Reach across the generations

"Interdependence is and ought to be as much the ideal of man as self-sufficiency. Man is a social being." Mahatma Gandhi

As older persons become a larger and larger portion of the population, and as the Baby Boomers retire and begin to use up surplus funds available for Social Security and Medicare, younger generations may have to pay increasing amounts of support to ensure continued benefits. Younger generations worry that Social Security won't 'be there' for them. They worry that the existing benefits for older persons are too rich for them to support.

However, there is strong support for the way the generations reciprocate, both on the part of younger persons and older persons. Younger persons support programs for older persons as part of a societal agreement. Older persons, through caregiving and transfer of their wealth, support younger generations' educational needs and economic activities. Older family members are the principal source of financial support when their children and grandchildren encounter times of need. Older persons support general education and economic growth taxes because they know the importance of these factors for a vibrant society. Younger persons know that the programs for older persons will one day benefit themselves. In their surveys of public opinion, AARP consistently finds overwhelming support for Social Security.

What is needed is not a generational conflict, but a public policy that ensures that the medical and support benefits available to the older generation are available to all generations. As Paul Newacheck, a pediatrician and health policy scholar, states: "Framing the issue as competition between vulnerable groups only distracts us from the real challenges entailed in designing and building support for public entitlements that address the basic needs of children, older people, and others."

Additionally, there are numerous programs that encourage intergenerational sharing. These programs are located in adult day services centers, childcare centers, assisted living facilities, and schools.

Another issue in intergenerational relations is grandparents raising grandchildren. The number of grandparents who have responsibility for raising their grandchildren because of the incapacity of their own children is increasing. Over two million currently have that role and about one-third of these are over the age of 65. This is not an easy role for a person at retirement. The physical and social toll can be substantial, despite the strong potential for emotional fulfillment. Furthermore, this is a

global issue as catastrophes such as war and epidemics threaten an entire generation of parents, and grandparents must step in to assist.

CHECK OUT THESE WEBSITE RESOURCES:

Generations United is an organization that encourages intergenerational outlook, strategies and public policies: http://www.gu.org/

One organization that has actively promoted intergenerational programs is the Environmental Protection Agency. What a tremendous idea to improve the environment – young folks and old folks working together: http://www.epa.gov/aging/ia/examples.htm

On the grandparents raising grandchildren issue see AARP's related site: http://www.aarp.org/families/grandparents/raising_grandchild/

The National Center for Grandparents Raising Grandchildren: http://www.wmich.edu/grandparenting/

SUGGESTIONS FOR FURTHER RESEARCH

Hayslip B Jr, Kaminski PL. Grandparents raising their grandchildren: a review of the literature and suggestions for practice. Gerontologist. 2005 Apr;45(2).

Newacheck, P.W. & Benjamin, A.E. (2004). Intergenerational Equity And Public Spending Health Affairs, 23, no. 5.

BUSINESS OPPORTUNITIES

Financial counseling for older persons who wish to leave a legacy for their children; retirement education and planning for the younger generations so that Social Security is not perceived to be the sole source of retirement income. Case management for grandparents who have charge of their grandchildren. Consulting on establishing intergenerational day services programs in the workplace, especially for larger employers.

POLITICAL ISSUES TO WATCH

Despite the strong support for intergenerational exchange of resources and for Social Security and Medicare, expect to see continuing debate on financing of Social Security and Medicare. Growing numbers of older persons will require more benefits and contributions of younger workers must increase.

An older person's home is a castle – and it's often too big.

A house means home and hearth and a place where friends and family gather. With aging, the home takes on even more psychological value. It is often a place that holds the memories of a lifetime – rooms that served as the back drop for life's triumphs and tragedies, and, its attic and basement hold the personal treasures acquired over a lifetime. Each item – linens, china, toy trains, books, wedding dresses, photographs, knick-knacks – can conjure up a person or time that is now gone.

Over the last 50 years, the average size of an American home has increased from about 950 square feet to 2,500 square feet.

Homes of older persons also hold large amounts of equity. Most older persons (80%) own their own homes. Homeownership has been an effective way of building wealth. Many older persons' homes could be sold for considerable profit in the current housing market.

Yet for many, especially for many older women, the family house has become the proverbial albatross around their neck.

For most women of the generation born before 1945, the maintenance of a home was the responsibility of the male spouse. Even if large repairs such as plumbing, electrical work, or remodeling were contracted out, the man handled the large numbers of small maintenance and repairs that a house needs – a screen replaced, gutters inspected and cleaned, shelves hung, garage door off alignment. It's not that older women could not learn to do these tasks, but a lifetime of spousal specialization of household tasks has not prepared generations up to this point for this responsibility.

Further, the number of contractors who want to deal with minor home repairs is decreasing. As neighborhoods change, older persons have fewer resources to rely upon for assistance. Older persons are a special target for scams involving home repair and maintenance.

Older widows in homes they own have been found to be more depressed after the death of a spouse than apartment dwellers. Not only do they now have the burden of home repair, but they may be more isolated and afraid of living alone in a large house.

A further argument working against maintaining an older home is the increasing energy costs which tax an older person's budget. Unused rooms need to be heated and thus the home heating costs are unnecessarily high.

Older persons are considering new housing options which include a floor plan that allows for a bedroom and full bath on the first floor, smaller yards or community maintained yards, more energy efficient materials and design in the house, and universal access design features. They are also seeking a community with access to shopping and cultural activities. So in the future expect to see denser communities composed of smaller homes with greater accessibility to amenities.

Another housing topic needing attention is the availability of home repair and home modification services within a suburban community. Expect a blossoming of ramps leading up to the entrance of suburban homes, and inside, expect adjustments to doorways, counter heights and bathrooms to accommodate increasing frailty and disability of some older persons. Expect newer homes to have been constructed with universal design features as normative.

CHECK OUT THESE WEBSITE RESOURCES:

Whether an older person relocates or moves to a new house, principles of universal access design should be incorporated. This is the Center for Universal Design at North Carolina State University: http://www.design.ncsu.edu/cud/index.htm

Another new service available through the internet is handyman referral websites. These sites are like yellow pages for a person's local area, but they include a basic screening to ensure contractors have necessary credentials and licenses, and the site includes user reviews. For an example, see Servicemagic at http://www.servicemagic.com/

When it is time to move, services of a "senior move manager" may be of assistance in helping older persons and their families to downsize and relocate. See the National Association of Senior Move Managers: http://www.nasmm.org/

SUGGESTIONS FOR FURTHER RESEARCH

Evans, G.W., Kantrowitz, E. & Eshelman, P. (2002). Housing quality and psychological well-being among the elderly population. J Gerontol B Psychol Sci Soc Sci. 2002 Jul;57(4):P381-3.

BUSINESS OPPORTUNITIES

Home redesign to make the home more energy efficient and more useable for persons with disabilities; relocation and downsizing services as noted above; handyman and home delivery services; refinancing services including home equity loans.

POLITICAL ISSUES TO WATCH

Many older homeowners receive a tax break on their property taxes either through the locality or the state. As the value of older persons' homes rise and the numbers increase, some may try to roll back this reduction. Protections for older homeowners against fraud and scams should increase as this incidence increases.

Graying suburbs.

Building affordable single family homes on their own plot of land was a major achievement of America in the last half of the twentieth century. People relished the escape from crowded urban living in rental apartments to their own homes in neatly laid out suburban communities. The movement was a perfect combination for a burgeoning housing industry and automobile industry because you needed a car to cover the distances between home and work. As the century progressed, houses grew bigger, plots larger, and the distance between home and commercial areas increased. The lower the density of the community, the better. The suburbs were designed for families and children. The car remains essential to suburban living. Now, 75% of older Americans live in suburban communities.

Yet, this same freedom becomes a prison when driving is no longer desirable or, in some cases, even possible. It is estimated that 10% of older persons don't drive, usually for medical reasons or because they are increasingly uncomfortable with their ability to drive. As with everything, more aged baby boomers will only increase the number who don't drive.

Most elders would prefer to 'age in place' in the communities where they raised children and have lived for many years. A lack of viability for cost-effective mass transit and an absence of walkable communities are side effects of suburban living. The low density makes deliveries and pick-ups for medical appointments and shopping often cost prohibitive. Low wage labor for housekeeping and home care becomes more problematic due to the difficulty in affording a car to reach the suburbs.

There are two major changes needed to meet the growing needs of older persons in the suburbs. The first is improved transportation options. Traditionally, this has meant a system allowing older persons to schedule rides to medical appointments and for shopping and personal errands through publicly available vans. Another model is the use of volunteers to provide rides for older persons. Such drivers may come from programs coordinated by a variety of private non-profit agencies including the Red Cross, churches, and community centers. There is also the potential for ride-sharing arrangements. For example, older persons might purchase 'shares' of a limousine service that would obtain a set amount of transport over the course of a year. Another option is a return to a delivery service method where essentials are brought to the neighborhood or delivered from local businesses – the Milkman or Domino pizza model.

A second area of change is in residential zoning limits. Some families would like to add a 'mother-in-law' suite as a rental unit, but often suburban communities frown on the introduction of rental units to communities. A related option is elder cottages, temporary housing placed on the property for the elder relative

to live in until their demise when the temporary housing is then removed; this option also faces zoning limitations. Finally, suburban houses might be turned into small board and care homes housing up to 5 older persons. This model has been shown to be an effective and preferred housing option for older persons with dementia. But such homes are usually met with strong opposition by homeowners in the community who fear a threat to property values.

Some localities reduce taxes for older homeowners. Why? The cost of educating children continues to soar and more taxes are needed to cover more children. An empty-nester couple in a four-bedroom suburban home doesn't generate the demand for education expenses that a family with children would; therefore, localities encourage older homeowners to stay put by reducing their tax burden.

CHECK OUT THESE WEBSITE RESOURCES:

Estimating the Impacts of the Aging Population on Transit Ridership, a report by The Transportation Research Board (TRB), a division of the National Research Council, which serves as an independent adviser to the federal government and others on scientific and technical questions of national importance: http://trb.org/news/blurb_detail.asp?id=5867

Smart Growth America is a coalition of national, state and local organizations working to improve the ways we plan and build the towns, cities and metro areas we call home: http://www.smartgrowthamerica.org/aging4.04.html

SUGGESTIONS FOR FURTHER RESEARCH

Frey, W. H. (2001). Seniors in suburbia. American Demographics; Nov 2001; 23, 11

Lucy, W. & Phillips, D. (2006). Tomorrow's Cities, Tomorrow's Suburbs. Washington, D.C.: APA Planners Press.

BUSINESS OPPORTUNITIES

Service provision in the home or home delivery on scheduled routes; smaller neighborhood stores accessible by walking; delivery of products by US Mail or shipping services; directories of services; home shopping options – internet or cable or good, old yellow pages; personal and community-wide transportation services; home repair and maintenance.

POLITICAL ISSUES TO WATCH

Tax relief for older homeowners at the local, state and federal level; the high cost of gasoline; demand for improved infrastructure to encourage walking and biking such as sidewalks, bike paths, pedestrian friendly intersections; demand for on-demand transportation services and bus links in suburbs..

The Power of Elder Voters

Making the government work demands participation in the political system. Voting power plus participation in politics equals more political power. Older persons participate at higher rates than younger persons. In the last election, 70% of the elderly voted while 42% of younger persons voted. Comparatively that's almost two elderly votes for each youth vote. As the number of older persons increases their proportionate voting power grows.

All three levels of government – local, state, and national – are important for gerontologists. The local level is often important for services to older persons. Some local governments fund a variety of services for their older residents. They often deal with transportation issues and community planning to take into account the needs and desires of their older residents. Often, they sponsor senior centers and many older adult services and activities.

State governments fund services for older persons. They also monitor and regulate home and community-based services, assisted living facilities, and skilled nursing facilities. The State Unit on Aging authorizes the formation and services of the Area Agencies on Aging (see next chapter). Older people are extensively involved in the politics of state government as advocates, active participants and volunteers in party organizations, and, of course, as voters.

They take similar roles at the national level, especially around issues such as Social Security and Medicare. They are considered a significant voting bloc in national elections. However, they rarely vote as a bloc. Usually the 'senior vote' divides fairly evenly between the major candidates.

There are three organizations that reflect strong advocacy on behalf of older persons. Count on these groups to educate you on issues critical to optimal aging. Key groups are AARP, National Committee to Preserve Social Security and Medicare, and the Kaiser Family Foundation. AARP, the American Association of Retired Persons is thirty-five million strong and one of the most powerful consumer organizations in the country. The National Committee to Preserve Social Security and Medicare is the pre-eminent organization fighting against efforts to dismantle the successful Social Security and Medicare systems. The Kaiser Family Foundation is a great source for information on health care issues and has excellent coverage of aging issues.

CHECK OUT THESE WEBSITE RESOURCES:

AARP: www.aarp.org.

National Committee to Preserve Social Security and Medicare: http://www.ncpssm.org/

SUGGESTIONS FOR FURTHER RESEARCH

Daniel J. B. Mitchell, Pensions, Politics, and the Elderly: Historic Social Movements and Their Lessons for Our Aging Society. Armonk, NY: M.E. Sharpe, 2000.

Binstock, R.H. Old-Age Policies, Politics, and Ageism. (2005). *Generations, Vol 29,* Issue 3, 73-78.

BUSINESS OPPORTUNITIES

Political consultants to candidates and to lobbyists who need a focus on aging issues.

POLITICAL ISSUES TO WATCH

Debates about the benefits received by older persons especially Social Security and Medicare. Ensuring voting quality and access for older persons to avoid situations such as in Florida in 2004. Continued discussion of the role and power of AARP. Zoning disputes over temporary 'mother-in-law suites' on the property.

The Aging Network: One of the Best Kept Secrets

This secret needs to be shared. There is a nationwide network of places to go for help to find needed services for older persons. The Aging Network was set up under the Older Americans Act, first passed in 1965. The Older Americans Act established an agency for older persons at each level of government in the U.S.

At the Federal level, there is the Administration on Aging (merged now into the Administration for Community Living). Its role is to coordinate programs for older persons among the agencies in Washington and to lead the rest of the aging network in helping society assist older persons.

At the state level, each state has a State Unit on Aging. These agencies develop programs and advocate for older persons in state government and they lead the Area Agencies on Aging in that state.

In localities around the nation there are Area Agencies on Aging who provide assistance and services directly to older persons in their communities. There are 655 Area Agencies on Aging.

They have different names based on their history and community, but there is one that serves every locality in the U.S.

So wherever older persons live, there is an agency to call for needed help. There is a website at the Administration on Aging that provides links to the right Area Agency based on zipcode, city or county:
http://www.eldercare.gov/Eldercare.NET/Public/Index.aspx

Here's a partial list of the services Area Agencies provide:

- Information and referral (I&R)
- Outreach services
- Transportation
- Care management
- Employment services
- Senior centers
- Congregate meals programs
- Adult day services
- Volunteer programs
- Home-delivered meals
- Homemaker
- Chore
- Telephone reassurance
- Friendly visiting
- Energy assistance
- Emergency response
- Home health
- Personal care
- Respite care

Unfortunately, resources available to these agencies are limited. They cannot serve all the elders who are in need. By law they do have to concentrate on those in greatest economic and social need.

They do, however, provide information to everyone. Area Agencies are a great place to start to seek help for an older person. They can direct an older person or their family member to a geriatric case manager or another agency that may be able to provide services that address elder needs. This is especially helpful for out-of-town relatives and friends who are attempting to assist older loved ones through long-distance caregiving.

In 2012, the Department of Health and Human Services formed the Administration for Community Living (ACL). This new entity now includes the Administration on Aging, the Administration on Intellectual and Developmental Disabilities, and the the Center

for Disability and Aging Policy. Because the services needed are often similar, many state governments are moving toward a closer collaboration between their State Units on Aging, their offices on developmental disabilities, and agencies for disability services.

CHECK OUT THESE WEBSITE RESOURCES:

The Administration on Aging: http://www.aoa.gov/

The National Association of State Units on Aging is an association of State Units on Aging that supports these agencies to achieve their mission: http://www.nasuad.org/

The National Association of Area Agencies on Aging does the same for these local community organizations: http://www.n4a.org/

SUGGESTIONS FOR FURTHER RESEARCH

Applebaum R, Kunkel S, Wilson K. (2007). Transforming data into practical information: using consumer input to improve home-care services. Gerontologist. 2007 Feb;47(1):116-22.

Carbonell J. (2003). The aging network and the future of long-term care. Journal of Gerontological Social Work, 2003; 41 (3/4): 313-21.

Strupp H.W. (2000). Area Agencies on Aging. A network of services to maintain elderly in their communites. Care Management Journals, 2000 Spring; 2 (1): 54-62.

BUSINESS OPPORTUNITIES

Consulting opportunities at all three levels especially as the Area Agencies become more sophisticated and stretch into other health and social services arenas. They will need expert guidance. Service provision – check the list of services above. Although some Area Agencies provide their services using their staff, others contract for all services. If you provide one of these services, Area Agencies may be a source of a stable contract.

POLITICAL ISSUES TO WATCH

The Aging Network is severely underfunded, yet they are a logical resource for a coordinated system of long-term care services. Watch how nursing home owners and other providers of long-term care and home and community-based care agencies struggle over meager resources and reimbursements for long-term health care. Look for consolidation of aging services agencies and centers serving persons with disabilities. Watch debates over persons not wanting to link aging and disability.

Where have all the caregivers gone?

Growing up I remember my mother juggling the caregiving needs of her mother and father, three aunts and three great-aunts. None of the aunts had any children and my mother was their primary younger caregiver. Little did I realize at the time what a harbinger of the future was my mother's role.

As life expectancy at early ages improves, parents conceive fewer children, families grow smaller. Extended kinship networks decrease in size. A few generations of families with only one child result in the absence of aunts, uncles, and cousins. At the same time, the life expectancy of older persons is increasing. One child may have the responsibility of support for two parents, four grandparents and up to eight great-grandparents. Two single persons who marry will have, potentially, double this responsibility – support for 28 older relations who have no siblings or cousins.

The support is not one-way. Older parents and grandparents provide substantial financial, emotional, and task-related support to their offspring. This type of societal structure allows for the concentration of significant attention and support for single children.

However, a person who is thirty-five years old may have parents who are around sixty years of age and grandparents who are 75 years of age, the latter age a traditional marker for the beginning of frailty. Although care of the grandparents will fall

most heavily on their daughter or daughter-in-law, the involvement of the granddaughter will be important if there is no other female relative. (Care for aging relatives is traditionally a female responsibility.) That granddaughter may also have responsibility to assist with care of her husband's parents and grandparents.

Add to this the fact that women participate in the workforce to a much higher degree than in previous eras, thus reducing the amount of time available for caregiving. Finally, the mobility of American society means that the caregiver often does not live in the same city as their parents and grandparents.

The demands of caregiving can result in loss of wages or of employment, with profound effects on the caregiver's family lifestyle. The burden of intensive caregiving also often adversely affects the caregiver's health and emotional well-being. This is especially true when the loved one receiving care has dementia or a related mental illness. Everyone agrees that the title of Nancy Mace's book about caregiving of persons with dementia – The 36-Hour Day – aptly describes the experience. On the positive side, caregiving can lead to a deepening and opening of relationships among family members that is healing for both the caregiver and the loved one receiving care.

What does the future hold? With the decrease in family available for informal caregiving, older persons will rely much more on friends and formal services. It's imperative to join and build networks of friends who will help each other when care is needed. Elders will also rely more on formal services such as home care and assisted living residences and nursing facilities when needed. Much care will be coordinated long-distance with the family caregiver depending on a local geriatric case manager and home care team to provide needed hands-on assessment, planning and care.

CHECK OUT THESE WEBSITE RESOURCES:

Two good sites for support and education about caregiving are the National Family Caregiving Association:
http://www.nfcacares.org/about_nfca/

and the National Alliance for Caregiving:
http://www.caregiving.org/

Of course the Administration on Aging is always a good place to begin a search for information, including information on the National Caregiver Support Program:
http://www.aoa.gov/AoA_programs/HCLTC/Caregiver/index.aspx.

SUGGESTIONS FOR FURTHER RESEARCH

Pinquart, M & Sorensen, S (2003) Differences between caregivers and non-caregivers in psychological health and physical health: a meta-analysis. Psychology and Aging, Vol. 18 (No. 2): p. 250-267.

Mace, N.L. & Rabins, P.V. (2006). The 36-Hour Day, (4th Edition). Baltimore: Johns Hopkins University, 2006. Even though geared to caring for persons with Alzheimer's disease, there are valuable insights into caregiving generally in this work.

BUSINESS OPPORTUNITIES

Geriatric care managers are persons who assess and coordinate services for persons with chronic illnesses and frailty. With scattered families their services should be in demand. Home care services of all types that handle caregiving needs, e.g., transportation, food delivery, bill-paying, personal shopping, house cleaning and help with personal care. Respite care services. Job counseling for those who are juggling caregiving and occupational demands. Financial advice on managing an elder's finances when appropriate.

POLITICAL ISSUES TO WATCH

Long-term health care is the major part of our health care needs that receives little support from government sources (except Medicaid). The recent CLASS Act that would have offered long-term care insurance on a voluntary basis to all citizens was terminated before it began due to cost concerns. As family size decreases and more formal types of paid care are needed, expect to see advocacy for increased government support, especially in tax credits, for caregivers. Also, we should see increased advocacy for better protection of caregivers' employment status, an expansion or refinement of the Family Leave Act.

Aging and Technology

Technology will embrace older persons and older persons will embrace new technologies. The continued technological innovation will change the way products and services are delivered, change the way relationships are formed and maintained, and the way older persons interact with their environment.

The aged adapt well to technological change. The current cohort of older persons grew up without typewriters, TV, calculators, ball point pens, the interstate highway system, and direct deposit of checks. The baby boomers had TV, but cellphones, the internet, electric guitars, and computers have changed their world significantly. These short lists don't even touch the medical technological breakthroughs that have revolutionized health care, e.g., widespread immunizations, the artificial heart, organ transplants, pacemakers, implanted infusion pumps.

Despite the stereotypes of an old dog not learning new tricks, older persons do very well in adapting to a changing world.

Changes seem to be accelerating in five ways that will affect older persons. First, as for everyone, is the Internet. It is the new infrastructure of contemporary living. It facilitates information gathering, but also communication, shopping, banking, socialization, and health care.

Second is the cellphone. Although the current generation of older persons has adopted this new technology slowly, their rate of use is rapidly rising, especially with the availability of a wider variety of cell phones. Ninety percent (90%) of Americans own a cell phone. Expect older persons to communicate more with family and friends by smart phone and to receive information and alerts in many areas including medical information by cell phone. For the baby boomers music on their cell phones will be critical to their well-being.

The third way technology will affect older persons is in their homes. Aside from automating the functions of a home, expect new technologies to assist frail older persons to maintain themselves in their own home. For example, the personal emergency response systems that allow a person to call for help after a fall are now in widespread use. Health monitoring systems, or computerized nursing stations, can now take a patient's vital signs and transmit them for review and intervention

as needed. 'Smart' homes, under development in universities around the world, will eventually monitor an individual's movements in the home, and deviations from habitual patterns can trigger responses by health care professionals.

Another area for technological change is the TV and related cable systems. Almost 60% of households have basic cable. In the future expect cable and TV to deliver interactive programs, social visiting options, and health care interactions.

Finally, older persons, as the greatest users of health care, will see phenomenal changes in health care services and delivery. Aside from the changes in in-home support, expect less intrusive and more ubiquitous diagnostics, including genetic assessment. Multi-function personal medical monitors, enhanced brain surgery through neuronic control, and nano-healing.

CHECK OUT THESE WEBSITE RESOURCES:

Adapting to new technology is easier with a helping hand; organizations like Older Adults Technology Services train and support the use of technology by older persons: www.oatsny.org

As an example of a way to access needed services via the internet, see the Senior Navigator program in the Commonwealth of Virginia that combines internet information about health care and social services with a cadre of local volunteers to assist older persons to find the resources they need: www.seniornavigator.org

SeniorNet is an organization dedicated to educating older persons about computers and the Internet: www.seniornet.org/

SUGGESTIONS FOR FURTHER RESEARCH

Feist, H., Parker, K., Howard, N., & Hugo, G. (2010). New Technologies: Their Potential Role in Linking Rural Older People to Community. International Journal of Emerging Technologies & Society, 2010, Vol. 8 Issue 2, p68-84.

BUSINESS OPPORTUNITIES

Plentiful. In all the areas mentioned above there are opportunities for development of services and products which target an aging group of people, whether it's adapting products for use, educating in the ins and outs of new technologies, or providing services using the new technologies, it's a rich field for entrepreneurship.

POLITICAL ISSUES TO WATCH

The most salient political issue is the digital divide not only between older user and younger user but also between rich and poor. Advocates will demand basic access to the internet and basic cell phone service for all persons. As technology changes legislation will be passed to assure access. The cost of medical care will continue its increase, due in part to innovative technologies for chronic disease care. What care processes should be covered by public and private insurance programs and reimbursement are sure to be contentious issues.

Employment

Retirement is a phenomenon of the twentieth century. It could not happen until society had the wealth to support individuals after they exited the workforce. Working until disability or death is the historical norm. Now some employment is often considered an important piece of retirement. Many older Americans choose to work beyond the traditional retirement age for reasons of finances, work/professional connections, and social links. Other older Americans have to work beyond retirement age because they don't have enough savings and retirement income to live on.

In the coming years, expect a more multi-generational workplace. Although age bias will not disappear, the changing age structure of the American society means that there will be fewer younger workers available and so, in certain employment fields, older workers will be prized. Older workers with the right skills will benefit from a shortage of workers available to fill positions.

Older women are taking more advantage of these opportunities than older men. While older men are retiring earlier, older women are increasing their proportion in the workforce.

Also expect to see more flexible options for older workers involving phased retirement, part-time work and seasonal work. For maximum success in using the American workforce, companies will solicit and support older workers. With older workers in receipt of basic health care through Medicare, more part-time opportunities will be available so that firms can save on health care costs.

When do older persons retire? It depends on how four issues come together: the difficulty of the job, the physical capacity of the older person, the desires of the older worker, and the amount of money available for retirement.

Work can become difficult for older workers, both physically and mentally. Jobs with substantial physical demands also may be perceived by older workers as increasingly difficult. In industries with extensive technological change, there may by a tendency on the part of older workers to retire rather than learn a new skill set. Second, if the older worker develops disability of any kind they may consider retirement as a preferable option to continued employment. Other older workers may have developed hobbies or avocational interests that they wish to pursue full time and this could lead to retirement. But, often, the most important factor is money, or the availability of resources and income that can support the individual when they retire.

CHECK OUT THESE WEBSITE RESOURCES:

AARP has a section on its site for older workers and job seekers: http://www.aarp.org/bulletin/yourlife/0905_sidebar_2.html

Quintessential Careers is a site that offers much information for older job seekers:
http://www.quintcareers.com/mature_jobseekers.html

SUGGESTIONS FOR FURTHER RESEARCH

Christensen, Kathleen & Catsouphes, Marcie-Pitt, (2005). Accommodating older workers' needs for flexible work options. Ivey Business Journal Online, (July-August 2005), pp. 1-4.

Slack T. & Jensen L.J. (2008) Employment hardship among older workers: does residential and gender inequality extend into older age? Journal of Gerontology B Psychol Sci Soc Sci. 2008 Jan; 63(1):S15-24.

BUSINESS OPPORTUNITIES

Employment support services for older persons interested in working. Human resource opportunities as companies seek to attract workers from an older age group and support their current needs and desires.

POLITICAL ISSUES TO WATCH

With a growing number of older people, watch the issue of age discrimination, a problem that is sure to increase. There may be increased pressure on the older population to continue to contribute to Social Security by deferring retirement. By remaining in the workforce their drawdown of social insurance benefits such as Social Security and Medicare is delayed.

Age Discrimination

Age discrimination is against the law. A worker can file a complaint beginning at age 40. (Now that's always scary for 39-year olds.) We know that older workers continue to be productive in the workforce. But does age discrimination happen? Yes. We think of it mostly in terms of employment situations but it seeps into many other areas such as housing, income, and health care.

Health professionals discriminate by tending to dismiss symptoms in older persons, under-diagnose them and under-treat them. The whole health care system discriminates against those with chronic illnesses – and most of these are older persons. More time and money is spent on researching, diagnosing and treating acute care problems than on chronic diseases. Research, until recently, never included older persons; this leads to dosing complications when the new drugs are introduced based on research with young volunteers and the drugs are then used to treat older persons. Employers offer less health care insurance to older workers than they do for younger workers because of Medicare.

When the Census Bureau looks at poverty levels, income thresholds are lower for persons over the age of 65 than for those under the age of 65. The method for computing the poverty level assumes that older people need less food than younger persons. Only recently have health care and other expenditures for older persons been included and are still not widely used. It still reflects discrimination on the basis of age.

As for age discrimination in employment, employers often base their decisions about hiring, promotion, and termination on false stereotypes about older workers. Even when the credentials are equal, employers will favor younger persons. Advice for the older worker seeking a job often includes the message: find ways to look and act younger. Many older persons have suffered age discrimination but, knowing the uncertainty of successful legal action, have refrained from making a complaint. What looks positive for the future are two trends. First, baby boomers are an assertive group and may act more aggressively to protect their rights as they age. Second, they will be helped

by an expected shortage of workers thus making all workers, including older workers, more valuable to employers.

CHECK OUT THESE WEBSITE RESOURCES:

For the official policy, check out the US Equal Opportunity Employment Commission: http://www.eeoc.gov/facts/age.html

And, of course, AARP has a number of resources on work and age discrimination: http://www.aarp.org/money/work

SUGGESTIONS FOR FURTHER RESEARCH

Dipboye, R. L. & Colella, A. (2005). Discrimination at Work: The Psychological and Organizational Bases. Mahwah, NJ: Lawrence Erlbaum Associates..

BUSINESS OPPORTUNITIES

Opportunities for those in the elder law field as the number of older persons wishing to file formal complaints increases. Life coaches and employment counselors may see an increase in clients as older jobseekers explore how they can be perceived as more competitive or as they re-career. Potential is also there for health care organizations that cater to older persons provided they adopt a positive, upbeat approach to services.

POLITICAL ISSUES TO WATCH

Expect to see continued attention to the rights of older workers as legislators seek to expand the capacity of enforcement of age discrimination protections. Another area under judicial dispute is differential treatment regarding pension benefits and retirement accounts.

Managing elder care

Helping an older person through the maze of health and social services to obtain the care they need is one of the most difficult and fulfilling aspects of aging services. As a caseworker with older persons I saw firsthand the confusion in dealing with a system of specialized, fragmented services, of referral and counter-referral. The elder care system is filled with eligibility rules and a lack of coordination between health and social services agencies. It is difficult for an older person to obtain the services they need.

What's the solution? Professional guides and pathfinders – geriatric care managers. These are professionals, usually with gerontological and health or social service backgrounds, who understand the system. They don't necessarily obtain the services, but they help older persons and their families locate the right services.

They know the system and as the system becomes more complex older persons will need them more and more. They can assess the need and link to the correct services. They are worth the weight of their fees, especially for family members who have an elder in another city.

There may be more than one case manager. Sometimes a geriatric case manager is needed within a health care system just to coordinate around the different medical treatments and therapies needed. Each of our 'helping' systems often has their own case managers – health care, community services, home care, mental health care. Sometimes the right role for a gerontologist is to get all the geriatric care managers working together.

Think of it like building a house. A gerontologist can be the general contractor and work with all the independent contractors who have different specialized duties, such as the electricians, plumbers, framers, etc. Geriatric care managers are general contractors for the house of care for the aged relative or friend.

Formally, geriatric care management is defined as the use of a trained professional to assess the needs of an older person, develop a care plan to obtain services to meet those needs, and assist with the implementation of the care plan.

CHECK OUT THESE WEBSITE RESOURCES:

To find out more about geriatric care managers go to the site of the National Association of Professional Geriatric Care Managers: http://www.caremanager.org/

You can also find information at the National Institute of Aging site:
http://www.nia.nih.gov/health/publication/so-far-away-twenty-questions-and-answers-about-long-distance-caregiving

SUGGESTIONS FOR FURTHER RESEARCH

Cress, C. (2007). Handbook of Geriatric Case Management. Gaithersburg, MD: Aspen Publishers, Inc

Knickman, J.R. & Snell, E.K. (2002). The 2030 problem: caring for aging baby boomers. Health Serv Res. 2002 Aug;37(4):849-84.

BUSINESS OPPORTUNITIES

The field of geriatric case management is a young, emerging field but with the growing number of older persons, it is expected to be a key career in health care. Related fields are elder law, primary medical care, nursing, social work, physical and occupational therapies, and services such as in-home care, medical equipment and adaptive devices.

POLITICAL ISSUES TO WATCH

There are professional rivalries about which discipline is most qualified to provide care management services and so there may be advocacy efforts on the part of each to get certain disciplines designated as required for care management. To a certain extent, geriatric care management, as an innovative service, undergoes continual re-definition. It has long been a political concern that the need for case management is a symptom of a system of care that does not work as a system and is not understandable to the consumer. Thus, the need for case managers implies that the system is not working.

Everywhere around the world…Global Aging

By the middle of this century, one out five people in the world will be over the age of 60. In developed countries, it may be as high as one-third of the population.

As the benefits of better nutrition, environmental improvement, and population disease control extends to the world and life expectancy increases the population of older persons across the globe will grow. Although life expectancy in developing countries lagged behind developed countries in the last century, it now approaches parity. Once an individual reaches 60 years of age, life expectancy in most cultures around the world is about twenty more years. A million persons turn 60 every month. The proportion of the world's population that is aged is rapidly changing. In some developed nations, such as Italy and Japan, one in five persons in the society is over the age of 60. By 2050, it is estimated that almost 40% of older people in the world will live in China and India.

The average age in a society is dependent on fertility, mortality, and migration. There are societies that experience high growth in the number of younger persons through fertility and immigration thus making the average age relatively low in the society. Other societies, through low mortality rates and low fertility rates, experience a rise in the average age in the country.

In North America, Europe, China and Japan the average life expectancy is in the 70s and above. It is in the 60s in the rest of the world and less than 60 in sub-saharan Africa and parts of the Indian subcontinent.

Fertility policies in some countries have limited the growth of the younger population, but, as the population ages, there are then fewer caregivers to assist with care of older relatives. This has caused some nations to rethink their policies on fertility limits.

It's important to understand the different experiences of aging around the world. Within the diversity of human experience are ways of caring for, involving, and supporting older persons that may hold valuable lessons for other cultures. Aging is universal and a society's response to aging and the aged is also distinctive. For example, in Japan, 60% of older persons desire to live with their children while in the US only 3% feel so inclined. Social customs, structures of society, traditions and history all contribute to each culture's distinctiveness.

The principle dilemma is how to care for older persons who develop frailty in a society with a high dependency ratio, i.e., the number of older persons and children is high compared to the number of young and middle-aged persons. All societies around the globe are confronting this now. Western European nations, which have rich pension rights programs are grappling with the effect of supporting such pensions as their dependency ratio increases. Effects are also felt on labor supply, savings rates, and trade.

CHECK OUT THESE WEBSITE RESOURCES:

Global Action on Aging is a United Nations initiative that looks at the needs and issues affecting older people around the world: http://www.globalaging.org/

The Madrid International Plan of Action on Ageing puts forth over 100 recommendations for the full participation of older persons in the world's societies. It's a good overview of the issues affecting the world population of older persons: http://www.un.org/ageing/documents/building_natl_capacity/guiding.pdf

SUGGESTIONS FOR FURTHER RESEARCH

Available at http://www.hsbc.com/1/2/retirement/future-of-retirement

is a report of the HSBC Bank on attitudes toward retirement based on data from persons around the world. Some interesting perspectives on retirement, work and savings.

Chatterji, S. Kowal, P., Mathers, C. Naidoo, M. Verdes, E., Smith, J.P. & Suzman, R. (2008). The health of aging populations in China and India. Health Affairs, 27(4), 1052-1063.

Robinson, M., Novelli, W., Pearson, C. & Norris, L. (Eds.). (2007). Global Aging and Global Health. San Francisco: Jossey-Bass.

BUSINESS OPPORTUNITIES

As the issues of aging populations are recognized around the world consulting on pension redesign, financial planning, long-term care insurance may offer opportunities; language skills and cross-cultural experience would obviously be helpful. All the business opportunities of aging noted previously would apply here, especially as the number of middle class older persons around the world increases. One US opportunity may be catering to the growing number of older expatriates living around the world; one million Americans, many of them older Americans, live, at least part-time, in Mexico alone.

POLITICAL ISSUES TO WATCH

These will be country by country specific topics. However, we can expect work, retirement, pensions, health care to generate key global political issues.

Welcome to the New Frontier: Refire Your Aging

Welcome to the new frontier. It's an old metaphor but it still works. Never before in history have we had societies with such high proportions of older persons. It's redefining our economy, our relationships, our activities, our sense of who we are, in essence, ourselves.

The aging of the population is the most important social trend in this century. It matters how we treat older persons, how we live as aging people, and how we, when older, contribute to our society. As gerontologists, it's your responsibility and privilege to work with older persons so they can best achieve their goals.

Each person's experience of aging will be unique, definable only for themselves. Each person is, as always, an experiment of one. Yet, these 35 million (soon to be 70 million) experiments are coming together to change America.

We have talked about redefining what aging is, living well now so that we can live well later, learning how to stay healthy and save money, and where and how to get services.

We can walk into our aged years with groans and whines stunned by our chronological age, an age many of our parents

only dreamed of living to. Or we can refire our lives as we age, seeking out new sources of creative inspiration, new friends and lovers, and new ways to contribute and achieve in this society. You can make this happen for older persons.

In the new aging world, we need to forget what we know of aging based on the past. Don't be constrained by those images in the rearview mirrors. Start looking for tasks in this society that need doing and encourage older persons to jump in. Stop thinking about the decline you may have seen in the past cohorts of older persons and start thinking of them as dynamic members of the society. Join with them to find a quest, a wonderful, impossible quest, and, no matter your age, start off on a new journey.