The Oldest Old: A Fresh Perspective or Compassionate Ageism Revisited?

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IN THE FALL OF 1984 THE NATIONAL INSTITUTE ON Aging (NIA) publicized its funding of a major research initiative focused on "the oldest old," persons aged 85 years and older (U.S. Department of Health and Human Services 1984). This scientific initiative is a timely measure for better understanding the implications of population aging.

Preliminary findings from nascent research on this topic indicate substantial diversity among the oldest old. And NIA has taken care to emphasize that the use of 85 years as an age marker for the lower boundary of this age grouping is somewhat arbitrary.

Yet, a focus on the oldest old is highly susceptible to familiar mechanisms of distortion that may generate unwarranted stereotypes of persons in this older age range. Such stereotypes would reinforce present anxieties about population aging reflected in a number of contemporary issues of "intergenerational equity" that imply conflicts between age groups in the allocation of health and social welfare resources.

Many of the contemporary issues implying age group conflicts are spuriously constructed on the basis of inaccurate old age stereotypes, superficial reasoning, and unnecessary extrapolations from existing

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public policies. More important, they divert our attention from other ways of framing health and social welfare dilemmas that may be more useful for us to confront.

This discussion presents alternative ways of perceiving some of these issues, and argues that these alternatives are accurate descriptions of the dilemmas we face. In addition, it suggests that such alternative constructs lend themselves to a variety of options—ranging from market initiatives, through state and local government actions, to federal intervention—for coping practically with some of the challenges that lie ahead as we are in the process of becoming an "aging society."

The Spectre of an Aging Society

The spectre of an aging society materialized rather abruptly for Americans at the outset of this decade. We were suddenly bombarded by media pronouncements concerning the crises in financing Old Age Insurance and Medicare health benefits through the Social Security payroll tax. Our attention was drawn to the "graying of America"—the demographic trends that are bringing about unprecedented increases in the number and proportions of older persons in our society. We are becoming aware of the fact that our national government is spending as much on old age benefits as on national defense, nearly 30 percent of the annual federal budget.

As we begin to put these pieces together, the prospects of an aging society seem foreboding. Among the many anxieties that have been generated are: the economic burdens of an aging society; the moral dilemmas posed by the allocation of health care resources on the basis of age; labor market competition between older and younger workers within the contexts of age-discrimination laws, seniority practices and rapid technological change; and a politics of conflict between age groups. Moreover, the long-time dream that biomedical discoveries might dramatically extend the human life span now seems to loom as a nightmare because its fulfillment might exacerbate these perceived economic, social, and political problems.

These anxieties are partially based upon simplistic projections of twentieth century perceptions of older persons and patterns of age relations, and the ways in which those perceptions have become intricately embedded in our public laws and our private institutions. Such per-

ceptions and their institutional manifestations have reflected an underlying *ageism* that consists of: the attribution of the same characteristics, status, and deserts to an artificially homogenized group labeled "the aged;" and the assumption that many of the biomedical, behavioral, economic, and social characteristics we conventionally associate with older persons are inevitable conditions of old age.

Ironically, the most elementary principles derived from scientific studies of aging and older persons contradict these characteristics of twentieth century ageism. It is evident that: older persons are notably diverse in emotional, physical, behavioral, economic, social, and political characteristics; and much of our behavior and the conditions that we experience in old age are shaped by the full life course of experiences in our youth and throughout our adult years. Nonetheless, American society has adopted many policies that treat all old people as if they were alike. At the same time we are not far-sighted enough to undertake collective actions directed toward children, young adults, and the middle aged, for the purpose of shaping the conditions of our old age.

The intents and effects of ageism—unlike those of racism—have not been wholly prejudicial to the well-being of its objects, the aged (c.f. Butler 1969). Indeed, until recently, many elements of ageism have been impelled by compassionate concerns for the welfare of elderly individuals, and expressed through a number of policies providing benefits and protection to older persons on the basis of old age.

If twentieth century ageism persists, however, contemporary anxieties about population aging may be well-founded. Extrapolations based upon demographic trends and current policies toward older persons understandably engender foreboding images of the future.

But perceptions of old age and age relations are somewhat malleable. And the public policies that express such perceptions are even more susceptible to change. By the time the "aging society" emerges it could be something rather different from a simple projection of contemporary arrangements, driven by mechanisms of demographic change.

One of the central challenges in actively coping with the implications of population aging is to move toward a better-informed perspective on old age, age relations, and institutional expressions of them. We will need to recognize the diversity of older persons as well as the life-course context in which each of us is shaped for old age. This fresh perspective may enable us to reframe issues concerning age relations and societal responsibilities toward older persons. And from

these reframed issues may flow a series of new practical choices for both public and private institutional arrangements in the twenty-first century.

The Oldest Old as a Fresh Perspective

The research initiative focused on the oldest old by NIA is a salutary first step in meeting this challenge. Although efforts to learn about this age group are just beginning, it is already evident that even when one systematically examines persons aged 85 and older, "the elderly" are still notable for their heterogeneity, and many of the conditions that we commonly associate with old age are not inevitable (e.g., the Atkins, Cornoni-Huntley et al., Manton and Soldo, Minaker and Rowe, Rosenwaike, and Soldo and Manton articles in this issue of the *Milbank Quarterly*).

Substantial diversity within the group aged 85 and older can be seen, in part, as simply an artifact of an age cohort that has been diverse throughout its existence, maintaining that distribution of characteristics as it enters a new age category. But there are other factors at work as well. Some of the diversity can be seen as the outcome of the policies in our society that serve to reinforce the distribution of certain characteristics throughout the life course (Nelson 1982). For example, much of the income distribution among persons aged 60, 70, 80, and 90 can be traced to their work histories and the public and private pensions that are structured to pay benefits on the basis of those histories. Other distributions of characteristics among the oldest old can be linked to such factors as the incidences of certain chronic diseases and disabilities in this older age range, the tendency of women to live longer than men, and many other factors that may distinguish those who survive to age 85 and older from those who do not.

Early portraits of the oldest old suggest that ensuing investigations of this population will provide timely data to help us forsee the implications of population aging. But a critical issue is: How will these data be interpreted and used?

Scholars in the 1980s should have no difficulty interpreting such data in a professionally responsible fashion. Substantial improvements in theories and methods for studying aging during the last two decades

(see Maddox and Campbell 1985) have made contemporary investigators aware of the complex interplay among three analytically distinct perspectives: processes of aging through the life course; characteristics of different age cohorts; and the potential effects of historical periods upon all individuals and cohorts. Consequently, unlike many of those who interpreted earlier waves of research on older persons, scholars of the oldest old will neither undertake one-dimensional explanations for their findings, nor extrapolate implications of their data very far into the future. The first wave of investigators who have generated data on this group are well aware of the reasons why even the characteristics of the oldest old are likely to change very rapidly as new cohorts enter the category of those aged 85 and older (see Suzman and Riley in this issue).

But will those who are not informed and professionally responsible scholars interpret these data in the same fashion? Key elements in the answer to this question lie in the use of an age marker—85 and older—not only to structure the initiative on the oldest old, but also in the interpretation of that marker by journalists, policy analysts, partisans, and irresponsible scholars. Will they distort it by generating new stereotypes of the oldest old and thereby engender the construction of a new fabric of compassionate or dispassionate ageism? If so, the consequences may be deleterious.

One can hardly criticize NIA for using an age marker to generate research on a swiftly growing segment of the older population—indeed, of American society—that may have substantial impacts and about which little is known. To be sure, the specific age marker is rather arbitrary and, as Suzman and Riley note, before long one may wish to push it up to 90 or 95. But this is not an important issue. Especially in the light of NIA's mission, its approach is reasonable.

Nonetheless, although the rubric of "85 and older" has been fashioned as an instrument to gain some knowledge in a timely fashion for coping with the implications of population aging, it may well be used as a double-edged sword. Even as it cuts through ignorance, it may also be used—in stereotyped isolation—to slice off the 85-plus grouping from the rest of us, with some grave consequences for the old and for the quality of life and nature of justice in our society. Before considering such consequences and what might be done to guard against them, perhaps it is worth considering why and how attention to the oldest old could become distorted.

The Seeds of Distortion

The "Young Old" and the "Old Old": A Notable Precedent

In some ways this focus on the oldest old can be viewed as an attempt to reinvigorate, update, and enrich a perspective on older persons and age-group relations that was generated by Neugarten (1974) more than ten years ago. Neugarten challenged predominant stereotypes of the population group conventionally termed "old" by highlighting its diversity and drawing attention to an increasing number of older persons who were relatively healthy, active, and reasonably well-off financially. She labeled such persons "the young old" as a convenient way of contrasting them with those older persons who more closely fit the old-age stereotypes of frailty, inactivity, and poverty (whom she labeled "the old old"). Neugarten built upon this observation that age was becoming increasingly inaccurate as a marker for approximating one's health, social, and economic status and roles, by extending her argument in subsequent articles (1979, 1982) to a criticism of public policies that provide benefits and protection on the basis of age rather than on the basis of specific needs for collective assistance.

Neugarten's attempt to break down age-based stereotypes has been substantially distorted in the past decade. To illustrate her point she presented data grouped by conventional and unconventional age markers. These age markers were quickly converted by journalists, policy analysts, partisans, and scholars to establish the young old and old old as new conventions for age stereotyping.

Persons aged 65 to 74 are now commonly referred to as the young old and are perceived to be healthy and capable of earning income. If retired, they are seen as a rich reservoir of resources to be drawn upon for providing unpaid health and social services and in fulfilling a variety of other community roles. Persons aged 75 and older are now termed the old old and tend to be saddled with the traditional stereotypes of the elderly. Moreover, instead of confronting the issue of whether *need* rather than *age* is the relevant basis for structuring certain social policies, many policy analysts and public officials are fudging the issue. They consider policy options that would simply substitute age 75 (and other old ages) for a variety of younger ages now used as crude markers in public policies to approximate those within the older population who may need collective assistance.

The Present Context

The attention being given to the oldest old in the mid-1980s is at least as susceptible to distortion as was Neugarten's earlier effort. This is an era in which public resources are viewed as scarce. "Reducing the deficit" is the overriding imperative of domestic politics. "Containing health care costs" is one of the most popular issues of the day. And population aging is widely perceived as exacerbating the problems of health care financing and leading to painful moral dilemmas in allocating health care resources. In such a context the consequences of distortions that may be brought about through ageism can be especially pernicious if the symbolic age marker for old-age stereotypes becomes 85 years and older.

Even though early journalistic portrayals of the oldest old have not been distorted (e.g., Collins 1985), it is highly probable that the 85-plus age marker will be seized upon to generate stereotypes for this "newly discovered" age grouping. The oldest old may soon be enshrined with the old old and the young old in the pantheon of hyperbolic rhetoric. Consider, for instance, the fevered milieu of contemporary public discussions about health care cost-containment. These discussions have been punctuated by repeated public references to the high proportion of Medicare that is expended on persons who are in their last months of life (e.g., Schulte 1983), by reports that the governor of Colorado has suggested that terminally ill old people have a "duty to die and get out of the way" (Slater 1984), and most recently by a decision of the New Jersey Supreme Court that extended the so-called "right to die" to "incompetent patients" when it can be "deduced" by others that the patient would have refused a life-sustaining treatment if she or he had been competent (Schreiber 1985).

The Mechanisms of Distortion

Tabloid Thinking. This milieu is ideal for the growth of "tabloid thinking," one of the major mechanisms that Allport identifies in the process of scapegoating. As Allport (1959, 13–14) notes in his description of tabloid thinking,

> Periods of social strain bring out vividly the helplessness every individual feels in the face of worldwide forces. He must seek to

> simplify the issues in order to make possible some understanding of this social chaos. . . .
>
> An issue seems nicely simplified if we blame a group or class of people rather than the complex course of social and historical forces.

For those who are ready to simplify the extraordinary range of complex factors and issues involved in health care costs, the oldest old would seem to be an ideal tabloid symbol. It is easy to imagine that the seeds planted through categorical identification of persons aged 85 and older can grow to become a metaphor for wasteful expenditures and other perceived problems in the financing, organization, and use of our health care resources.

The temptation to use the oldest old as a tabloid symbol will hardly be confined to journalists. Since the 85-plus age category is more accurate as a crude approximation for relatively high morbidity rates than either 75 plus or 65 plus, program analysts may seize the age of 85 and over as a marker for generating policy options, and health care administrators and practitioners may be inclined to use it as a frame of reference for making decisions in the allocation of health care resources. Similarly, the 85-plus age marker is more accurate than a younger one as an approximation for other characteristics that have been conventionally associated with old-age categories—inadequate income, social isolation and dependency, and a predominantly female population. Hence, a focus on the oldest old may breathe new life into a number of old-age stereotypes that have been fading in recent years.

Extrapolation from Existing Policies. The temptation to use the age of 85 and over as an "improved" marker for issues that have been traditionally identified with old age is likely to be reinforced by the conventional habit of predicting through extrapolation from the specific frameworks of existing policies. Even though we continually amend our policies, we are fond of the dramatic impact that can be achieved by projecting them into the future as though current policies were immutable. This custom leads to such pronouncements as Secretary Califano's (1978) widely publicized estimate that more than 40 percent of the federal budget would be spent on benefits to the aged early in the next century, and the Urban Institute's estimate of 63 percent by the year 2025 (U.S. Senate. Special Committee on Aging 1980). Although a number of changes have already been made in both Social

Security and Medicare policies since these pronouncements, as well as major changes in federal expenditures for financing budget deficits and for defense, the projections are still frequently and widely cited. As presaged by the Torrey article in this issue, we will probably soon see a spate of projected costs of persons aged 85 and over extrapolated from current policies and demographic trends. As a by-product, the oldest old will become artificially homogenized as one of the major categorical groupings for cost/benefit analyses of health care and other expenditures, without regard to the diversity of characteristics within the group.

Incrementalism and Pragmatism. The seeds of distortion may similarly and perhaps most importantly be fertilized by our American penchant for reforming existing policies through incremental changes, and by our pride in our capacity to make pragmatic compromises. Even as we celebrate the anniversaries of public programs—the 50th for Social Security, the 20th for Medicare, Medicaid, and the Older Americans Act, the 10th for Supplemental Security Income and the Employee Retirement Income Security Act—we tend to sanctify them and the principles that they seem to express. We regard proposals for drastic reform as "politically unfeasible." We would rather make minor cosmetic adjustments that we can rationalize as "preserving the integrity of the program," rather than confront the failure and success of the program as it functions in a contemporary context. We would rather not deal with issues involving major value conflicts such as whether it makes sense to have programs that provide collective benefits on the basis of age rather than need. The framing of the oldest old as a population category may make it easier to avoid such conflicts by facilitating a new set of incremental, pragmatic adjustments.

Throughout five decades American policies toward older persons have been adopted and amended in substantially different social, economic, and political contexts. And the reasons why each policy was originally enacted and subsequently altered can be, and have been, subjected to widely variant interpretations. In the 50 years since the Social Security Act of 1935, innumerable explanations of its intent have been profferred. Among them are: an attempt to get older workers out of the labor market to make room for younger workers; a response to political pressures from large, grass-roots old-age pension organizations; a desire to provide immediate financial assistance to millions of older persons who had no other significant source of income; and a far-

sighted construction of the first leg of a "three-legged stool" (Social Security, pensions, and savings) that would ultimately provide adequate retirement income (see Achenbaum 1983). Similarly, among the interpretations applied to the enactment of Medicare in 1965 have been: a way to make health insurance available to retired persons who could not obtain it once they were no longer eligible for employee group plans; a mechanism for income redistribution; and an intentional "first step" toward the eventual establishment of a universal national health insurance program (see Marmor 1970).

Regardless of interpretations of the "original intent" of any of these and other policies toward aging, by the late 1960s a common theme was taking shape. Through the cumulative impact of many disparate legislative actions American society had adopted and financed a number of age-categorical benefit programs and tax and price subsidies for which eligibility is not determined by need.

This theme was strengthened as a number of old-age-based interest groups that had begun to develop a national presence in the 1960s repeatedly articulated compassionate stereotypes of older persons (see Binstock 1972; Pratt 1976). Since the early 1960s these "advocates for the aged" have been telling us that the elderly are poor, frail, socially dependent, objects of discrimination, and above all *deserving.*

From the mid 1960s through the late 1970s, virtually every issue or problem affecting some older persons that could be identified by these organizations became a governmental responsibility. Programs were established to provide: nutritional, legal, supportive, and leisure services; housing; home repair; energy assistance; transportation; help in getting jobs; protection against being fired from jobs; special mental health programs; a separate National Institute on Aging; and on and on (Kutza 1981; Estes 1979). American society had learned the catechism of compassionate ageism very well and expressed it through a variety of governmental programs and objectives.

Because older persons came to be stereotyped as "the deserving poor" they have been exempted from the Calvinist screenings that are applied to other Americans in order to determine whether they are worthy of public assistance. Programs for the aged have not been historically subject to the disdain and stigmatization attached to other welfare programs in American political culture. Indeed, the architects of these old-age programs have developed their own cliché to explain this phenomenon to us: "Programs for the poor make for poor programs."

In effect, compassionate ageism has made a special case of "the aged," creating for older persons a unique sanctuary from the harsh judgments of the Protestant work ethic that is so intricately embedded in American political ideology and culture. In truth, of course, any of the needs for collective assistance that have been symbolized by old age can be found extensively among persons of all ages. Yet, the great bulk of our social welfare and health expenditures is for benefits to the aged.

But the elderly—marked by ages 60, 62, 65, and older ages in federal programs—have come less and less to reflect the traditional compassionate stereotypes of poverty, frailty, social dependency, and discrimination. And as the costs of Social Security, Medicare, and other old-age programs have increased, the special sanctuary of welfare policies that has been created for older persons appears to be threatened. But, with all the current rhetoric about targeting scarce resources to "the truly needy," enactment of major reforms that would substantially redistribute the benefits of these programs on the basis of true need rather than age would violate the norms of pragmatism in American politics. It is far easier to maintain the basic principles implied by the structures of current old-age programs through minor and gradual changes in benefit and reimbursement procedures, rates and mechanisms for generating revenues, and age criteria for eligibility and protection.

A focus on the oldest old can feed in very well to this penchant for incrementalism and pragmatism in American politics by providing a rubric through which a higher ground of compassionate ageism can be staked out to legitimate marginal upward changes in the age markers used in current policies. Several old-age policies have already been amended to push upward the ages of eligibility and protection. The age of initial eligibility for full Social Security benefits is scheduled to rise gradually from 65 to 67 early in the next century. And the 1978 amendments to the Age Discrimination in Employment Act advanced protection for older workers from age 65 to 70. Especially in the light of this latter change, which concurrently outlawed mandatory retirement before the age of 70 in most sectors of employment, it is very conceivable that the age of eligibility for Medicare could be raised to 70. After all, one of the prime rationales for Medicare is the difficulty of obtaining substantial group health insurance once one leaves the work force.

If the age of 85 can be used as a stereotype for morbidity, poverty, and social dependency, it will serve the interests of those who analyze

and generate policy options, as well as the politicians who act upon those options. The incremental changes it can symbolically justify will save resources without violating the norms of political pragmatism and the principles reflected in existing programs. Such options will not, of course, appeal to the various aging-based interest groups that have a stake in claiming to represent the largest possible constituency that can be regarded as old.

Possible Consequences of Distortion

These various mechanisms through which a focus on the oldest old may become distorted are familiar phenomena in American politics and public discourse. Perhaps the possible implications that may flow from distortions of research on an 85-years-and-older age grouping can be best understood in the context of the contemporary impacts that these mechanisms have already had.

The Current Distortions

Since the late 1970s a new set of stereotypes concerning older persons has emerged and taken hold as axioms of public rhetoric. These axioms have virtually reversed those of compassionate ageism that had prevailed for more than a decade—that the aged were poor, relatively impotent politically, and "deserving" because their disadvantaged plight was forced upon them by the frailties and social dependencies of old age as well as the prejudices of a youth-oriented society. We now find—in the media, political speeches, public policy studies, and the writings of scholars—a fresh set of axioms:

- The aged are relatively well-off, not poor.
- The aged are a potent political force because there are so many of them and they all vote in their self-interest.
- Because of demographic changes, the aged are becoming more numerous and politically powerful and will be entitled to even more benefits and substantially larger proportions of the federal budget; they are already costing too much and in the future will pose an unsustainable burden on the American economy (see Binstock 1983).

Even as the earlier compassionate stereotypes concerning older persons were partially unwarranted, so are these current ones. They are generated by applying simplistic assumptions and aggregate statistics to a grouping called "the aged" in order to gloss over complexities. If one chooses to compare changes in the median or average income of all older persons with changes in the income of other groupings, one can assert that the aged are relatively well off. If one wishes to ignore abundant evidence to the contrary (see Hudson and Strate 1985), one can assume that the votes of older persons are determined by issues—particularly one issue above all others, that they will respond to that one issue self-interestedly, and that they will all perceive their self-interests to be the same. If one pretends that outlays for Medicare, Old Age Insurance, and other policies are immutable and mechanistically determined by demographics rather than by legislative and administrative decisions, one can conclude that the aged constitute an unsustainable burden for the American economy.

These new ageist stereotypes appear to have been immediately precipitated by the so-called Social Security crisis in an era of economic instability. Their roots had been developed through decades of compassionate ageism. It was to be expected that a perceived shrinking of resources would be accompanied by a shrinking of compassion (Binstock 1981). But the ageism that had been previously constructed remains intact.

The Oldest Old and "Intergenerational Equity"

Among the many consequences of the new tabloid axioms concerning older persons, age relations, and old-age policies, one is particularly worth noting in the context of this discussion because it may be exacerbated in an especially unfortunate fashion if a focus on the oldest old is distorted to generate stereotypes of morbidity, poverty, and social dependency for the 85-plus age grouping. This is a present widespread tendency—among journalists, politicians, scholars, and self-styled advocates for age-based interests—to frame public issues in terms of conflicts between age groups.

Although there is no systematic evidence of age-group conflicts within the American populace as yet, public rhetoric may be fomenting it. Moreover, the very framing of issues in these terms is important, in itself, because their structure interferes with our capacity to perceive

phenomena in terms of other frameworks that may be more accurate and propitious.

The phrase "intergenerational equity" has become a sweeping conventional label for describing tradeoffs in health and social welfare allocations. In turn, it has spawned a series of metaphors for more specific dilemmas in particular sectors of American life.

Justice between Age Groups. "Justice between age groups" (see Daniels 1983) has become a metaphor for concern that widespread rationing of acute health care will be brought about by cost-containment measures such as Medicare prospective reimbursement on the basis of diagnosis-related groups (DRGs), and restraints upon cost-shifting to patients who do not rely primarily upon governmental health insurance. But there is no inherent reason why issues of justice in allocating health care resources need to be framed on the basis of age. One can just as easily frame tradeoffs within age groups or without regard to age. Better yet, one can frame tradeoffs between expenditures in the arena of health care and other arenas.

If the issues of health care allocations continue to be framed as tradeoffs between age groups, it does not take much imagination to envision that a stereotyped group termed the "oldest old" will be assembled in the front row of the trading block. For instance, the excerpts available from the January 1985 New Jersey decision extending the right to die do not contain any reference to age as a criterion for decisions to terminate life-sustaining care. Yet, the journalist who covered the case for the *New York Times* had no hesitation in reporting that "the New Jersey court has mapped out how the decision to stop care may be made for incompetent, elderly, dying patients in nursing homes" (Kleiman 1985). Similarly, consider the repeated public discussions of the high proportion of Medicare expenditures on persons who are in their last year of life. There are many spurious elements in the construction of such figures (see Scitovsky 1984). Nonetheless, such constructs are likely to persist, albeit with refinements. And they will stay focused on older persons—not on middle-aged persons, youths, or infants who are in their last months of life—because of preoccupation with financing and outlays for the age-categorical Medicare program, as well as because of the social values implicit in economic theories that undergird policy analyses of the costs and benefits of public expenditures (see Kutner 1985). The focus may well be sharpened on the oldest old—as they join the old old and the young old in the

field of vision—when policy options are developed to cut down on public reimbursement to acute-care settings in the last months of life.

Long-term Care. "Long-term care" has become a metaphor for health care and social supports for chronically ill and disabled older persons, even though the rates of such conditions and the costs of dealing with them are significant among persons of all ages (see Brody 1984–1985). Here again the issue is framed to emphasize the enormous economic, social, and familial burdens of caring for the needs of older persons, without comparable public attention to the implications of such needs and burdens generated within other population groupings. To the extent that attention is given to such needs within younger populations, however, rehabilitation—whether focused on the goals of compensation for or restoration of lost functional capacities—receives a reasonable amount of attention. But only a few (see, e.g., Williams 1984; Brody 1984–1985) have given attention to rehabilitation as a dimension of treatment for the chronically disabled elderly, even with the modest goal of maintenance of existing functional capacities. Stereotyping of the oldest old would likely reinforce current tendencies to perceive the challenges of chronic illness and disabilities in terms of care, without rehabilitation, for elderly residual human entities as their functional capacities gradually erode or precipitously decline just before death.

Increasing Dependency Ratios. "Increasing dependency ratios," conventionally expressed as the size of the retired population relative to the productive working population, has become a metaphor for anxieties about the economic burdens of population aging. This construct grossly distorts the issues involved because it is largely an artifact of an existing policy, Social Security, that finances benefits to retirees through a tax based on the paychecks of workers.

The most general problem with this construct lies in the use of the number or proportion of workers to assess the productive capacity of the economy. Productive capacity is a function of a variety of factors including, for example, capital and technological innovation as well as number of workers. Hence, issues involving productive capacity and numbers of workers should be expressed in terms of "productivity per worker" in order to take account of a full range of macroeconomic variables (see Habib 1985).

More specific flaws in common usage of dependency ratios express the ubiquitous impact of ageism in the framing of issues. Age categories

are used to estimate the numbers of workers and retirees—rather than actual and projected labor-force participation rates—even though the two approaches can yield substantially different results. In addition, the focus on retirees as "the dependent population" ignores the fact that many retired older persons are economically independent. It also ignores children and unemployed adults of any age who are economically dependent; for instance, recent research has indicated that a decline in "youth dependency" during the decades ahead may well moderate or even dominate the economic significance of projected increases in "elderly dependency" (Crown 1985).

Despite the involvement of such distortions in discussions of increasing dependency ratios, those discussions have seemed to generate several assumptions that may be unwarranted. One is that we will need a far greater number of workers in the decades ahead than can be projected from current age norms for entering and retiring from the labor force. A second is that older persons who would retire under present policies will want to and be able to work in the future if the incentives to retire and the ages associated with them are marginally adjusted. And a third assumption is that there will be employer demand for such workers.

Although these assumptions may be unwarranted, they would probably be given impetus by the emergence of a stereotyped oldest old population. The more that the ages of 85 and over are equated with frailty and social dependency, the easier it is to perceive all persons at younger ages—in their 70s and below—as capable of and obligated to earn their own livings rather than to perceive them as exempt from the Protestant work ethic. One can well imagine that policies setting the ages of eligibility for retirement benefits will soon begin to move upward, well before the minor changes that are scheduled to be phased in gradually in the next century. Yet, we know today that two-thirds of current Social Security beneficiaries choose to retire before age 65 even though it means that they receive reduced benefits, and we also know that poor health as well as the availability of pension income is a powerful influence in decisions to retire early (see Schulz 1985, especially chap. 3).

The Political Power of the Aged. "The political power of the aged" is still another metaphor frequently used to misframe issues in terms of age-group conflicts. As implied earlier, election exit polls have shown over and over again that the votes of older persons distribute

among candidates in about the same proportions as the votes of middle-aged and younger persons (see, e.g., New York Times/CBS News Poll 1980, 1982, 1984). Studies of old-age-based interest groups do not reveal them to have a significant, let alone a decisive impact on decisions affecting Social Security, Medicare, and other policies providing benefits directly to older persons. Indeed, the scholarly literature indicates that organized demands of older persons have had little to do with the enactment and amendment of the major old-age policies such as Social Security and Medicare (see Hudson and Strate 1985; Cohen 1985). Rather, such actions have been largely attributable to the initiatives of public officials in the White House, Congress, and the bureaucracy who have focused on their own agendas for social and economic reform (see, e.g., Derthick 1979; Marmor 1970). The impact of old-age-based interest groups has been largely confined to relatively minor policies, enacted from the mid-1960s to the mid-1970s, that have distributed benefits to professionals and practitioners in the field of aging rather than directly to older persons themselves (Lockett 1983; Estes 1979; Binstock 1972).

Nonetheless, the image of so-called senior power persists because it serves certain purposes. It is used by journalists as a simple tabloid symbol to simplify the complexities of politics. It is marketed by the leaders of old-age-based organizations who have many incentives to inflate the size of the constituency for which they speak, even if they need to homogenize it artificially in order to do so. It is called to attention by politicians when they desire an excuse for doing nothing or for not differentiating themselves from their colleagues and electoral opponents. And it is attacked by those who would like to see greater resources allocated to their causes.

In the past few years the image of senior power has been used frequently to frame conflicts between age groups. A notable recent example was an article by Preston (1984), president of the Population Association of America, in which he pleaded for more public resources to be devoted to children. He structured his argument so as to draw stark contrasts between children and the elderly with respect to their status and the funds expended on them, and characterized the two groupings as being in direct competition. One of Preston's prime explanations for the comparative success of the elderly was "their political influence," which he attributed to their increased number, their high voting rates, and their self-interested voting behavior on

issues. He presented nothing, however, to show that older persons' votes distribute differently from those of persons of any other age group. All he did to buttress his argument that there is a self-interested tendency among older persons was to cite responses to one question in one opinion poll. He did not even begin to deal at all with the complexities or the realities of voting behavior and its tenuous linkages to the processes of policy decision making.

What might happen if a stereotyped focus on the oldest old were to become an added ingredient to such caricatures of the American political process? As social welfare and health program cutbacks began in 1981, the children's lobby immediately expressed concern that it would be pitted against the old-age lobby in a struggle to gobble up the shrinking pieces of the pie. Fearing that the old-age lobby would win this struggle, a former deputy assistant secretary for the Department of Health and Human Services under President Carter proposed that parents who have children under the voting age of 18 be enfranchised with an extra vote for each such child (Carballo 1981). Alternatively, why not treat morbid and dependent elders like children? Someone may soon revive Douglas Stewart's (1970) proposal, that all persons be "disfranchised . . . at retirement or age 70, whichever is earlier"—a proposal made because its author was disgusted by his perception that the aged were responsible for the election of Ronald Reagan as governor of California. In comparison with age 70, age 85 would be an easy target for disfranchisement.

Intergenerational Equity vs. Other Forms of Equity. These few examples of current metaphors for tradeoffs in the politics of health and social welfare allocations—justice between age groups; long-term care; increasing dependency ratios; and the political power of the aged—may be sufficient to illustrate: that issues are being framed in terms of conflicts between age groups; that the frameworks are frequently constructed from spurious and unwarranted assumptions; and that if the oldest old were to become stereotyped as morbid, poor, and socially dependent, such stereotypes would perniciously exacerbate the implications of the issues that have been framed. Most important, the very description of issues in terms of age-group conflicts diverts our attention from other ways of viewing tradeoffs and options available to us that may be more accurate and more propitious.

To describe the axis upon which equity is to be judged is to circumscribe the major options available for rendering justice. The

contemporary preoccupation with so-called intergenerational equity blinds us to inequities within age groups and throughout our society. Because of the large costs of old-age-categorical programs and aggregate statistics on the status of the elderly, the plights of the most seriously disadvantaged persons within the older population are now largely ignored even though the benefit mechanisms in existing policies do little substantially to alleviate their distress. At the same time, the needs of seriously disadvantaged persons in middle-aged and younger-age categories are receiving little attention and emphasis. Through old-age-based programs we spend an enormous amount on health and welfare, but we are not a welfare state in the conventional sense of the term (see Myles 1983). In effect, we have created an "old age welfare state" that does not target benefits on the basis of need, even within the elderly population.

It may very well be that we do not want American society to become a welfare state in the broader sense. Viewed in this light our current expressions of age-group conflicts and our tendencies to extrapolate may serve us well. Since the current and projected costs of programs for the aging are perceived as unsustainable, attempts to curtail those costs are dominating our health and social welfare agenda. With our agenda thus occupied by issues of intergenerational equity, we are precluding from serious consideration any substantial health and welfare reforms—involving other issues of equity—that may be badly needed by those in distress and for the quality of life in our society.

Transcending Ageism and Extrapolation

Whether or not the United States will ever become a broader welfare state, it is certainly becoming an aging society in demographic terms. But the implications of population aging for our society do not need to be simple extrapolations from current perceptions of old age, age relations, and the institutional arrangements through which they are expressed. Extrapolation is only one of many modes of prediction and it is a relatively inaccurate one because the characteristics of society are dynamic, not static. Yet, we are confining our capacities to anticipate and cope with the implications of population aging to a narrow tunnel of vision in which greater numbers and proportions of older persons

are simply plugged into the existing framework of policies and institutional arrangements.

An aging society may be a very different kind of society from that with which we are familiar. Difficult to predict, but certain to occur, will be the impacts of technological innovations; structural changes in the economy, political system, and a variety of social institutions; the diffusion of ideas, goods, and services; and shifting relations between our nation and the rest of the world. Much easier to predict are the variety of characteristics that will constitute the older population grouping.

To anticipate the challenges of an aging society, one of the essential first steps is to inform ourselves about the diversity within the current and future cohorts of older persons, and the ways in which life-course contexts are shaping each of us for old age. The NIA initiative on the oldest old has been launched as such a step. Yet, for a variety of reasons presented in this discussion, the initiative is highly susceptible to distortion. The use of an unconventional and older age marker to focus research attention on a portion of the older population about which little is known may, in effect, stake out a high ground in compassionate ageism. And before long the compassion may erode, leaving us with the ageism expressed in policies and institutional arrangements that isolate a stereotyped grouping of the oldest old from the rest of us.

Equally important are steps, therefore, to frame issues that express societal health and welfare dilemmas in terms other than conflicts and categorical divisions between age groups. As illustrated earlier, many issues expressing such age-based conflict are spurious and unwarranted. Even to the extent that age markers are crude approximations for certain statuses, social roles, and societal responsibilities, they change swiftly. To rely heavily upon extrapolations from yesterday's (and even today's) age norms to predict and plan for the future makes little sense. Generating pragmatic options that express incremental changes in age-categorical policies to preserve the basic structure of current policies and institutional arrangements, will unduly delay our urgent need to confront fundamental dilemmas that will need to be resolved in meeting the challenges of an aging society.

If we can perceive issues that express equity in terms other than intergenerational tradeoffs and conflicts, those issues may generate a series of new practical choices for public and private institutional

arrangements in the twenty-first century. It is hardly within the scope of this discussion to set forth a blueprint for such arrangements. But perhaps it is appropriate to illustrate some of the ways in which health policy dilemmas that are being expressed in contemporary issues can be viewed in other terms.

Perspectives on Acute Care

As we know, a consensus that health care costs must be contained has developed in the mid-1980s among federal policy makers concerned with outlays and financing for Medicare and Medicaid, nonprofit and private insurance companies that reimburse hospital charges which include "cost-shifting" from publicly insured patients, insurance premium payers (including corporate employers that pay increasingly higher group health insurance premiums), and, apparently, the populace in general (Lou Harris and Associates, Inc. 1983). In turn, this consensus has led to a widespread concern that acute health care will be rationed on a more increased scale than it was even before the establishment of Medicare and Medicaid 20 years ago.

Population aging has exacerbated concerns about health care costs for several reasons. One reason is that among the many public and private initiatives to control costs the most widely publicized and far-reaching have been changes in reimbursement procedures under Medicare, which primarily insures persons aged 65 and older and without regard to their financial status. Another reason is that persons aged 65 and older, now about 11 percent of the population, account for about a third of health care expenditures in the United States. Simple extrapolations from present expenditure patterns and projections of the percentage of the American population that will be in this age grouping in the decades ahead serve to emphasize the portents of population aging for both acute and nonacute health expenditures. For example, current per capita hospital expenditures for persons aged 65 and over are 252 percent more than for persons under age 65; the "fastest growing segment of the population" (Suzman and Riley in this issue), persons aged 85 and older, use hospitals at a rate that is 77 percent higher than those who are aged 65 to 74, and 23 percent higher than for those aged 75 to 84 (U.S. Senate. Special Committee on Aging 1984, 369–73). Similar examples can be drawn regarding expenditures on physicians, drugs, and nursing homes. In this context, it is not

surprising that "justice between age groups" has become a metaphor for concerns about more extensive rationing of health care costs.

There is no inherent reason, however, why issues of equity in the allocation of acute health care resources need to be judged in relation to age. In their portrayal of how rationing works in the frameworks of fixed budgets of the British National Health Service, Aaron and Schwartz (1984) have shown how older age is but one of the prime criteria involved in rationing decisions there. They have also been careful to note that if extensive and explicit rationing takes place in American health care it may not take place along the same dimensions that it does in Great Britain.

If rationing does become widespread in the United States, it may very well take place primarily on the basis of the financial status of patients. Some rationing of health care has been taking place for a long time in this country, on the basis of economic as well as social and demographic characteristics. The establishment of Medicaid and Medicare in 1965 largely eliminated the phenomenon of "charity cases" by providing public reimbursement for the care of indigent patients and promoting the goals of equal care and equal access to care for all persons. Since then we have had the luxury of pretending that physicians and their associates in the health professions were doing everything they could for everyone. But as cutbacks in Medicaid and Medicare have accelerated cost-shifting from the medically indigent to those who have other insurance or can pay out of pocket—and as insurance companies, insurance premium and out-of-pocket payers, and state governments have reacted—the luxury of the pretense of equal access and care is eroding.

If we can put aside our immediate preoccupation with Medicare and the age-category principle that it expresses, perhaps we will see that it is the capacity of patients to pay for charges—out of pocket or through third-party reimbursements—that has a great deal to do with the allocation of care. Maybe the concern about old-age-based rationing is justified. But consider what would happen if Medicare coverage became sharply reduced, means-tested, or totally eliminated. Some older persons would be able to pay for extensive and high-quality care out of pocket, and many more would be able to afford to pay premiums that would insure most of the costs of acute care. Near-poor and poor older persons would be left in the same position as medically indigent persons of all ages. In this light we can more

clearly see that rationing, and its tacit judgments regarding the worthiness of human lives, might mean the reemergence of two-class or even three-class medicine.

"Justice between rich and poor" may be a better metaphor than "justice between age groups" for the dilemmas of equity we might confront in the rationing of acute care. With the issue framed on this axis the specific policy options we might generate and consider would be rather different from those we are contemplating now, and would more likely reflect the actual tradeoffs in the allocation of health care resources.

It is also possible that anxieties about extensive rationing are unwarranted because cost-containment is not an end in itself. To be sure, none of us may be willing to finance what we perceive as wasteful and excessive practices in health care. But if steps can be taken to reassure us that physicians, hospital corporations, medical equipment manufacturers, pharmaceutical companies, and medical malpractice lawyers are not receiving more than their "fair share" of health expenditures, then our hunger to contain health care costs may be satiated. Under such circumstances—which may be extremely difficult to bring about—Americans may very well want the best available care for everyone, even if they have to pay for it through taxes, as well as directly from their own pockets, and by trading off salaries and wages for employee-benefit health insurance premiums.

As many observers have pointed out (e.g., Schwartz and Aaron 1985) there is no inherent reason why 11, 12, 13 percent or more of our gross national product can not be expended on health care. Tabloid rhetoric notwithstanding, Medicare will not "go broke"; benefits, eligibility, and financing mechanisms will be changed, or the program could even be eliminated altogether. But after 20 years of socialization to the "rights" or "entitlements" provided through Medicare and Medicaid it could well be that Americans—reassured that they are not paying for waste and excesses—will not want to impose a ceiling on health care expenditures and/or be willing to acquiesce to the rationing practices that such a ceiling would impose.

Walzer (1983) has argued that notions of justice throughout history have not only varied among cultures and political systems, but also among distinct spheres of activities and relationships within any given culture or political system. Nothing requires us to devise or accept separate spheres of justice within the health care arena, either spheres separating age groups or spheres separating the relative wealthy from

the relative poor. We may prefer to delineate the health care arena as a single sphere of justice within which no such distinctions are made.

Perspectives on Long-term Care

Another set of widely shared concerns in the mid-1980s is the variety of challenges to be met in providing nonacute health care and supports for persons who are chronically ill and disabled on a long-term basis. Again, population aging has exacerbated or, more probably, generated these concerns. The optimistic argument presented by Fries (1983), predicting the compression of morbidity in old age, appears to be problematic (see Manton 1982; Schneider and Brody 1983) unless potential advances in treating such conditions as urinary incontinence, osteoporosis, stroke, and organic brain syndromes are achieved and have substantial impact in delaying the onset of chronic illness and disability to older ages (Riley and Bond 1983). Even with attention to the diversity within the older population, projections such as those presented in this issue by Soldo and Manton and Cornoni-Huntley et al. suggest enormous challenges in developing services and facilities for long-term care and rehabilitation, and in financing such services and facilities.

Understandably, these challenges have been framed as issues of population aging although, as indicated earlier, such illnesses and disabilities are substantial in the middle-aged and younger populations. But here again, the capacity of the patient to pay, or the willingness of the taxpayer to pay—not the age of the patient—is at the heart of the issue.

Persons of any age who have substantial resources can assemble all the needed services through the private market. Older persons who can afford and choose to join a growing number of "life-care communities" can ensure that they will get long-term care if they should eventually need it, by virtue of the actuarial viability of the financial arrangements they make upon entering the community (Winklevoss and Powell 1984). Some older persons have substantial amounts of home equity that they could convert to pay for long-term care and rehabilitation should the need arise, but a great many others do not (see Atkins in this issue). Medicare and Medicaid do not provide reimbursement for many nonmedical elements of long-term care that are often essential.

A few insurance companies are attempting to develop actuarial

parameters for marketing long-term care insurance because the potential dollar volume to be generated by premiums would appear to be irresistible. Recent research (e.g., Katz et al. 1983) has provided useful groundwork for delineating probabilities as to the onset of long-term illnesses and disabling conditions at older ages. Yet a major barrier to be overcome in the development of such insurance is how to avoid "adverse selection," the enrollment of a group of policy holders that constitutes a greater than average risk of the expenses involved in long-term care.

Although many have looked at the families of older persons as a financial or in-kind service solution to this problem, the family is not a panacea. Many older persons have no family (Rosenwaike in this issue). Some families are able and willing to finance care for their parents. Others are willing, but not able to do so. State laws requiring filial financial responsibility for parents' long-term care are proving to be unenforceable. Expectations that families will provide a greater volume of informal supportive care are unrealistic. Family abandonment of older persons is a myth; indeed, families are probably already stretched to their limits in providing physical, emotional, social, and financial supports for their chronically ill and disabled older and younger relatives (Shanas 1979; Brody 1985).

It is by focusing on the family, however, rather than on aging and older persons that we may gain a fresher perspective on responses to the challenges of long-term care in an aging society. For, as Brody (1985) has cogently observed, parent care is now an "expectable, though usually unexpected," family stress. Summarizing a stream of research studies conducted during the 1960s and 1970s, she points out that it is families, not formal service systems, that provide 80 to 90 percent of medically related and personal care, household tasks, transportation, and shopping to disabled persons who are not in nursing homes. According to Brody, about two-thirds of family care-givers are aged in their 40s and 50s, and as many as one-third are under age 40 or over 60. Hence, some of these care-givers are comparatively old themselves, and some have children still dependent upon them.

If parent care is already an expectable stress, how societally pervasive and intensive will it be in the context of increased population aging—in an aging society? What will the impact be if additional numbers of disabled older persons are added to such care for younger disabled and/or dependent family members?

Perhaps the best prospects for resolving the challenges of developing and financing long-term care and rehabilitation services lie with adult children—particularly middle-income children—who may be the source of substantial demands for new developments. Many adult children—aged in their 40s, 50s, and 60s—are confronting intractable dilemmas. Faced with the choices of expending (currently) $25,000 a year for high-quality institutional care, or institutionalizing a parent in a Medicaid warehouse—the "space age" version of the British Elizabethan poorhouse—or absorbing the economic, psychological, social, and other costs of maintaining a chronically ill person in their own home (perhaps while raising children or sending them to college), they may push strongly for new alternatives.

One arena in which this demand could be expressed is the private-sector market (see Brody and Persily 1984). Many adult children may be only too happy and able to pay for selected components of a continuum of care, not covered by either public or private insurance, that can make community or home-based alternatives to institutions truly viable. This demand may turn into a significant market for private enterprise.

Another way in which such a demand could be articulated is through collective-bargaining efforts aimed at reshaping employee group-insurance plans. If care for parents and others is to become a pervasive stress in an aging society, it is certainly conceivable that most of us would like to be insured against the possibility of having to pay extraordinarily expensive bills for long-term care and rehabilitation. Insurance companies would not have to worry about the issue of adverse selection if long-term care insurance were designed as an indissoluble portion of a group health insurance package. Premiums and benefits for maternity are indissoluble from basic health benefit plans today, regardless of whether it is possible or probable for a given individual in the group to have a child. If long-term care responsibilities are as pervasive as one anticipates in an aging society, its possibilities and probabilities would be distributed among a labor force in at least a rough approximation of the distribution for maternity benefits.

Still another arena in which the demand for long-term care financing may be felt is national politics. A distinct possibility is a compulsory national insurance program for long-term care (Bishop 1981), similar to the compulsory program of Old Age and Survivors Insurance. Indeed, if the demand for long-term care becomes strong enough, compulsory long-term care insurance may be considered as an option

to replace Social Security old-age benefits. We may, as a nation, come to consider it more important to insure against the financial catastrophes of long-term care and rehabilitation than against reduced income in retirement.

Finally, another way in which the demand for adequate long-term-care supportive services may find expression is through the development of locally felt senses of crises, and local government responses that finance such services. Crises generate powerful incentives to those who undertake to solve them, namely the people who directly feel the impact of them. If we review the history of the United States, we will find that fully developed services (beyond the token or symbolic level) have not emerged from national initiatives but from local crises. It was the extreme impact of sudden and large waves of immigrants from Europe in the latter half of the nineteenth century that led to the development of professional police services, fire protection services, and public health services. Similarly, development of community-financed services for an ever-growing chronically ill and disabled population may be generated through the crises in the lives of individuals and families that are felt widely and expressed profoundly in local communities. Even when resources are perceived as scarce, the identification of *essential* services is a dynamic process that continuously brings about different answers in the form of resource allocations at the community level. Cohesion in values for achieving such answers is always much easier to achieve at the community level than at the level of a mass society of 240 million persons. And in many communities, where middle-aged children are coping with the dilemmas posed by caring for their parents and other dependents, there may be substantial cohesion regarding the need to pay taxes for long-term care and rehabilitation services, and to cut back on other services and facilities.

Conclusion

These are but a few examples of how contemporary dilemmas can be perceived in terms that express neither compassionate and dispassionate ageism nor conflicts between age groups. Whether they are more accurate or even more propitious ways to frame issues is certainly open to debate. They have been offered as an illustration of the preoccupations with stereotypes, policies, and institutional arrangements

which reflect current perceptions of old age and age relations that divert us from alternative ways of attempting to anticipate and deal with the implications of population aging.

If we are willing to eschew extrapolation and perceive the future in terms that transcend twentieth-century old-age policies, we may enrich our perspectives and find practicable options that flow from them for coping with and shaping an aging society. The risks are minimal. At worst such unconventional perspectives may be labeled absurd. And even the half-life of the absurd is very short these days.

Ten years ago it would have been outrageous to suggest that Social Security benefits should be taxed. Today, by virtue of the Social Security Amendments of 1983, they are being taxed by the federal government. Now that Congress has opened everyone's eyes to the possibility, legislators in dozens of statehouses have introduced bills to tax Social Security benefits at the state level as well. Counties, municipalities, and special district governments may soon line up for their share.

Certainly, it should be clear by now that the political power of the aged—such as it is—does not prevent us from making major revisions in policies affecting old age. Since 1981 a great many important changes have been made in Old Age Insurance, Medicare, and other old-age benefit programs—changes that conventional wisdom perceived as counter to the self-interests of "the aged." The old-age lobby did not prevent them. Moreover, when the president who presided over these changes stood for reelection in 1984 he received nearly two-thirds of the votes cast by persons aged 60 and older (New York Times/CBS News Poll 1984). The myth of senior power need not limit our perspectives regarding what is politically possible.

Even as we begin to generate knowledge about the oldest old to inform our choices for the future, it is especially important that we examine the principles of equity implicit in the choices we frame. If we allow our thinking to be confined by our current policies and the principles they have come to reflect, we may very well find ourselves engaged in policy debates on age-group conflicts that are far worse than those we have experienced to date, trading off the value of one human life against another. Ultimately, the principles of equity that we use to describe our choices will be far more important than data for shaping the quality of life and the nature of justice in an aging society.

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