A NEW PARADIGM FOR THE OLD

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A new framework of services to the aged is proposed based on three interactive domains — gerontological laws, organizational laws, and the laws of self-interest. Each of these domains has changed so dramatically in recent years that the old paradigm of aging services is no longer functional. A crucial underlying principle of the new framework is that families have an ongoing moral obligation to take care of their parents that supersedes that of the community.

The real problem facing the Jewish community concerning the care for its parents is not posed by demographics or government. Rather, it is our mindset, our comfortable paradigms of thinking about care for the old.

A paradigm can be defined as a "set of rules and regulations (written or unwritten) that does two things: (1) it establishes or defines boundaries; and (2) it tells you how to behave inside the boundaries in order to be successful" (Barker, 1992, p. 32). As described in "Spirals," an article that appeared earlier in this *Journal* (Dunkelman, 1993), the old paradigm of the stand-alone nursing home is malconfigured to deal with today's evolving gerontological world. However, although the old buildings limit our options and our ability to address today's needs, any new building will *not* by itself break the cycle. Unless we look anew at the world around us and change our operating assumptions and approaches accordingly, we could easily fail programmatically and financially in any new building as we have done in the old. The real excitement of a new paradigm is that it is the reshaping of perception that stimulates new sets of behaviors from old people, from caregivers, from families, and from the community.

This article suggests a new framework to understanding aging services, new rights and obligations for all parties, and new policies that will ensure the integrity of our community's enormous investment and commitment to our parents and our future selves.

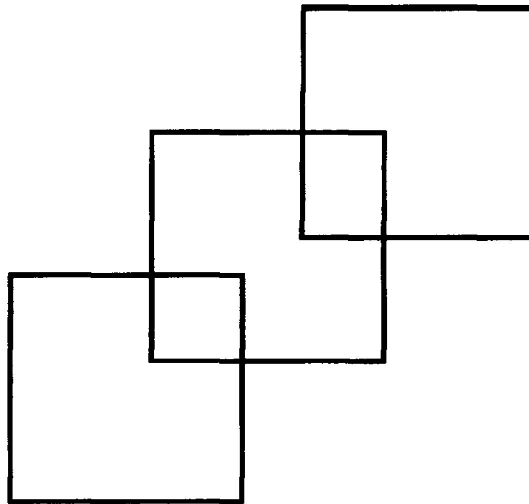
A PARADIGM LOST

The English Elizabethan Poor Laws form the foundation of the American approach to care for the aging. These laws established a clear demarcation between governmental and charitable responsibility; private charity was responsible for helping the lame, the blind, the old. Change came with the Depression, which forced government into providing support for needy elements of the population, support that had never before been deemed appropriate.

Onto that small mutation were grafted a series of laws in 1965 that established Medicaid, Medicare, and the Older Americans Act. Those few pieces of legislation grew by accretion to become the new foundation of our aging "policy." Few anticipated that Medicaid would spawn and become the regulatory and reimbursement vehicle for nursing homes.

These last three decades have witnessed an evolution of care into a scattered set of delivery sites. The nursing home became the refuge of the most frail, the less frail migrated to assisted living, and the most capable sought independent housing. Home health, government-sponsored housing, and senior citizen centers evolved under separate programs and were grafted onto this series of one-shot solutions. After the fact, this jumble was conceptualized as a "system" based on levels of care (Figure 1), which implies a logic, a thoughtful integrated approach. However, that was not the case.

Figure 1. Conceptualization of the aging system as based on levels of care.



This paradigm has broken down, as each of the separate levels of care is now overflowing. The deluge of frail older people has pushed them down from hospitals to nursing homes, from nursing homes to assisted living, from assisted living to apartments. This huge, silently occurring migration is a massive exodus, one much larger than that of Soviet Jews. The current buildings, staffing, reimbursement streams, and program supports never anticipated these new populations and are woefully inadequate for the tasks.

In addition, this system was flawed from the outset. The more that we learn about the heterogeneity of older people, that they become more different as they age, the more it become apparent that these are not *levels* of care but are in fact buckets containing people with a myriad of very different problems and required interventions. As a consequence, placement in any of the "levels" becomes more and more arbitrary, leading to disillusionment and confusion for the professionals and more cynicism from the aged and their children who never agreed to nor understood the construct in the first place.

A NEW PARADIGM

As the old continuity-based level-of-care model fades, it is critical that new models evolve that tease apart current notions of buildings, services, and reimbursement streams and that allow us to conceptualize and create more fluid new systems.

The new construct is built around three interactive domains or centers — gerontological laws, organizational laws, and the laws of self-interest (Figure 2). The understanding of each domain and of how and

Figure 2. Three interactive domains on which the new paradigm is based.

where they interact will shape the systems we build and the issues that emerge.

Circle #1 — Gerontological Laws

Any Jewish delivery system must start with the needs of old people and our commitment that each person be kept in the least restrictive, least medicalized, least institutionalized, least expensive, and most dignified environment as long as possible, as long as the client is not a danger to self or others. This law has a profound resonance and guides the development of any aging system.

Over the past 20 years we have realized that we can provide, in less restrictive environments, many of the environmental safeguards, programs, and services heretofore only available in nursing homes. For many older people, the traditional nursing home is no longer necessary, and it is neither the most appropriate nor the environment of choice for many old people. As a consequence, four major support locations are evolving as part of the new paradigm network of services — the community dweller's traditional home, apartments, assisted living, and nursing homes.

Services for Community Dwellers

An initial goal is to keep older people in their homes for as long as possible, providing home health, aides, housekeepers, and emotional support, plus on-campus adult day care, rehabilitation care, and medical care. By extending services into the home, we also extend the time in which people remain in the environment that they have shaped and has shaped their lives through the years.

As discussed in *Why a Jewish Home*, an earlier article in this series (Dunkelman, 1992) we are becoming much more sensitive to the person-environment relationship in old age. The physical and social environment, which has been shaped over many years of living, in turn shapes and reinforces the continuous sense of self that we call identity. It is frequently in the best interests of the individual to remain in the pre-senescent environment (the community dwelling) and to modify it to address the changes that may accompany aging.

All of these supports or services are variants of nursing home care, which can be seen as aging services in their most concentrated form. By teasing apart basic contextual issues (room, board) from aging services and stretching the former with tailored services from the latter, all parties benefit. Out-of-pocket costs are minimized, social networks and informal supports are maintained, and services can be dropped in and adjusted in a controlled setting. With the ideal alliance of formal (professional – paid) and informal services (family – unpaid), all the sundry supports can be maintained and enhanced.

Apartments

However, for many, at a certain point the home becomes a trap. The abode that provided shelter, independence, a safe harbor, and a launching vehicle for the individual to reach out and shape a stimulating life becomes too burdensome. The environment no longer provides dignity, but rather entraps and isolates. At this point, an apartment set in the middle of a stimulating social environment, one that both encourages activities and can accommodate support services, becomes a more attractive, life-enhancing environment. Ideally such apartments should be arranged around an ample public space for intellectual and physical stimulation. Studies reinforce anecdotal evidence that older Jews, in particular, desire continued community involvement and stimulation in their older years.

The apartment's physical design must enable people to age-in-place. With pull cords, no thresholds in the doors, low-pile rugs, and wheelchair-accessible appliances in the kitchen, an older person is not forced out of the apartment because of a physical handicap or limitation. In fact, the apartment must be designed *programmatically*

for aging-in-place. In contrast, most current housing for the aged is designed for the "well" aged, offering limited support services and discharging older people as they become more frail. Traditional "independent" apartments set up a disastrous cycle of isolating and terrorizing our own parents. Such apartment complexes house a very narrow group of older people — those too frail to be at home, but well enough that they need very few services.

Under the new paradigm, in contrast, new apartments anticipate and support frailty. In fact, older people will generally seek these apartments not for their square footage, but for the services they need or anticipate. In truth, these living arrangements are *Aparvices*, a hybrid combination of the words apartment and services, for it is the services that are most attractive. By encouraging older people to continue participating in public life, we can monitor losses and drop in supports on a timely basis to keep a person as safe and independent as long as possible.

Obviously there are limits even to this supportive environment. If tenants have enough money to pay the rent, but insufficient resources to purchase the services necessary to keep them safe, they can no longer remain. And, of course, a program cannot be designed to keep that person safe if he or she is alone and has dementia. The person then must be moved into a different, more supportive environment.

The older Jewish generation is extremely knowledgeable about these environments. They have seen variations of the *aparvices* in NORCs (naturally occurring retirement communities) and in some subsidized housing that is straining to drop in programmatic supports. The *aparvice* has become the living arrangement of choice for many older Jews. It offers enormous security (because of the backing of the Jewish community, not a for-profit company, which can fail financially), the aging-in-place philosophy, the services, a hook into the other components of care in the Jewish community, and a sense of community obligation that Jews have to one another.

Adult Home

Assisted living or personal care settings (here all collected under the rubric "adult home") are designed for a "spill-over" population coming from three directions. As the nursing home becomes a chronic hospital, people who in former days would have been nursing residents will live at the adult home. From aparvices will come residents who "age out" and have an increased need for more structured support or for more services at less cost. Finally, many people either living in their homes or in "traditional" unsupported senior housing will find that the adult home will offer a more enriched life.

In rough terms, one could view costs of the aparvice and the adult home as somewhat similar, but with the trade-off being that the aparvice offers more real estate, whereas in the adult home one receives more services.

Nursing Home

The new nursing home must be designed in a residential style and be programmed to create a non-institutionalized, private, higher quality life at lower costs. The design and program should also anticipate an increasingly more frail, more sick resident. Within the next 5 years, the average age will increase from the current 90 to 95 years; the average length of stay in the nursing home will plummet from 4 years today to approximately 1 year within the next decade. The reason for the increasingly debilitated resident profile is that the government is forcing nursing homes to capture the more frail, medically unstable older patients being discharged from hospitals and will continue to ratchet the reimbursement system to discourage nursing homes from admitting and retaining higher-functioning people. In effect, the nursing home is becoming a chronic disease hospital, and the

adult home becomes the "home for the aged" of the 1990s.

In summary, by shaping a system of different levels of care and different services, the Jewish community will be able to respond by keeping older people in lower levels of supportive environments longer so that they are not forced out of nursing home or adult home care into an unsafe environment. As older people spend a larger proportion of their years in a frail condition but are unable to enter a nursing home, we are developing subsystems of housing arrangements and services to support those people in dignity.

Circle #2 — Organizational Laws

Organizational law states that the organization has a right to thrive. It must meet its financial obligations and its commitments to the community and to present and future generations of old people. The organization also has a legal and moral obligation to meet all of the relevant regulations.

To fulfill the organizational imperative, each client/tenant/resident must "produce" sufficient revenue to cover all costs of his or her care. This revenue may come from the resident's own funds, from family, from government, from a community supplement, or from any combination of these. This critical reconceptionalization can move the organization from a retrospective analysis to a prospective one — from a crisis mode *after* the "underproductive" client is admitted and the organizational shortfall obligation is assumed to a threshold consideration of gerontological *and* organizational issues. An additional benefit is that community subvention can be reshaped from an organizational subsidy to an individual scholarship, thereby pulling the old person/client closer to the donor, which is of critical importance to the upcoming Baby Boomer generation of leadership.

The new paradigm must simultaneously address both gerontological and organizational laws and must be aligned with the direction of societal changes. For example, the desire of the Jewish community to meet the gerontological laws — to support older people in the most dignified, most residential, least expensive environment for as long as possible — coincides with the changing governmental reimbursement systems. These prospective case mix reimbursement systems encourage the pushing down, the devolution of frail older people into lower settings. At the same time the government is retreating from full reimbursement in the nursing home, it is developing the tightest scrutiny possible both to assure the quality of care for which it will no longer generously pay and to enforce a system of fines for noncompliance with the regulatory mandates; in effect, "give-backs" from the facilities.

To survive under the very stringent government reimbursement system, nursing homes and adult homes must meet their organizational needs with systems and strategies that ensure full payment. In this turbulent environment, the organization must at a minimum break even, if not be able to put away some money to deal with contingencies. To explore the strategies of "breaking even," this article again addresses each of the proposed categories of care, but in reverse order, starting with the nursing home.

Nursing Home

Medicaid originally paid the actual full cost of care, and families were absolved of all responsibility for their parents. Yet, over the past three decades the government has chipped away at the percentage of actual cost that it has reimbursed. As a result of this "genetic defect" (which goes to the heart of the Medicaid program), the nursing home population has historically been divided into two separate types of payers, Medicaid and private pay. The goal of nursing homes has been to fill as many patient days as possible with private pay patients, an increasingly more difficult task as more and more families legally (and illegally) transfer their parents' assets to qualify for Medicaid. And under the old

rule, it was not permissible for the home to even ask residents to pay for the difference between actual cost and the Medicaid reimbursement.

There are new strategies to address these issues today. For example, some states allow a facility to ask a family to pay "voluntarily" for the difference between a double room and a private room in the nursing home, which may amount to $14,000 per year. In this way, the older person pays full cost, either from their own funds altogether or as a supplement to Medicaid reimbursement.

Moving from the old paradigm of Medicaid versus private pay patients, the new paradigm classifies residents as either full cost or community subsidy. As long as laws are abided by, we need no longer care where the full cost comes from. Rather, the concern is that the full costs are met. The family may find it in its best interest to strip the assets legally, put the parent on Medicaid, and provide $14,000 per year to the nursing home to enable him or her to have a private room.

Historically, the home has been, in effect, giving away "scholarships" to older people, costing between $8000 to 15,000 per year per resident, and then, after the fact, requesting a subsidy from federation. Under this new paradigm, a family desiring a community subsidy would apply to the home for a "scholarship," claiming it desires a private room but has no money to subsidize it. The family would be requested to present each and every child's tax returns and assets for the last 5 years to the home's committee to determine whether it would qualify for the community-raised, limited "scholarship" funds. The additional $14,000 per year per "full-pay" private room generated by this policy could greatly increase revenue with no additional expense.

Another strategy is to download less sick clients to lower levels of care (gerontological laws), keeping the nursing home case mix average high in order to maximize Medicaid reimbursement.

The home must also attempt to maximize Medicare reimbursement for rehabilitation. With gymnasiums, pools, and contoured rehabilitation treatment spaces in the nursing homes, these facilities will be able to hire the best possible physical therapists and to develop a reputation for excellent geriatric rehabilitation. The effect will be to build Medicare costs and corresponding reimbursement.

Adult Home and Apartments

It is absolutely legal and appropriate to fill the adult home and apartments with full-pay clients and to "sprinkle in" services a la carte in order to keep tenants safe as long as possible in those environments. In the past the nursing home had a fixed income (from Medicaid) and ever-rising expenses. The new paradigm reverses this situation: fixing its expenses with a fixed mortgage and controlled labor costs while passing on the cost of additional services to the client on a per-unit-of-service basis.

Circle #3 — The Laws of Self-Interest

The laws of self-interest orchestrate and integrate the gerontological laws and organizational laws into a new functioning operating system. As we evolve from a fragmented single entity approach toward a system of overlapping, coordinated delivery sites and programs, the driving issue is how individuals and groups of individuals in the form of families, organizations, and communities interpret and act in their perceived best interests.

An understanding of these laws of self-interest is critical because the health care system has quickly moved from a supply-driven to a consumer-driven system. As short as 10 years ago, there were few alternatives for frail older people — mostly nursing home care — and generally there was a shortage of nursing home beds. As a result, the supplier of services, the facility, could dictate the terms of service. However,

today, the consumer has many options.

Traditional Assumptions Embedded in Aging Legislation

The assumptions embedded within government legislation for the aging developed in the 1960s have powerful ramifications. First, because the laws were designed to create a system for the poor (people on the margin), one must become "marginalized" to gain access to it. In fact, the entire system became marginalized. Second, and as a consequence, no new societal consciousness was developed. Each piece of aging legislation was a targeted, narrow-bore approach that neither orchestrated consensus around new understandings of aging nor created an overarching framework for old people. Third, the delivery system was producer/supplier oriented. With the belief that poor, marginal people should be satisfied with their handouts, the system was orchestrated around efficiencies of service and delivery and addressing patients' basic necessities. Fourth, because our social service system is grounded in the Protestant ethic, which associates indigence with individual responsibility, the policy was to not visit the sins of the parents on the children. As a consequence, the legislation cut off the child's responsibility for the indigent parent. The underlying assumption was that the middle-class would care for their own in programs and facilities more attractive than those developed for the indigent. Therefore, Medicaid was not envisioned as an attractive revenue source for middle-income families. Finally, the understanding at the time was that there was not much to be done for aging. Chronic disease associated with aging was viewed as inevitable — decline was inexorable and predetermined.

The legislation of the 1960s continues to be the backbone of "aging policy" in America. Our current difficulties have arisen because the underpinnings of all the assumptions embedded in that legislation have changed — the number of old people, their economic status, understandings of the aging process, and our perceptions of government and community.

New Wealth of the Old

The new, relative affluence of the aged is a function of the increase in Social Security benefits, pensions, and the value of assets that have appreciated during the post-World War II era of prosperity. For example, the average monthly Social Security retirement benefit rose from $29 per month in 1950 to $492 per month by 1987. Even after adjusting for inflation, that represents more than a threefold increase in little more than a generation. Some 60% of federal entitlements go to those over 64, even though they account for only 12% of the population.

Private sector pensions have also grown dramatically. As of 1987, assets of private and public pension plans totalled more than $2.2 trillion. More than half of all full-time employees in the private sector and approximately 85% of those earning more than $50,000 per year have some pension plan. Because income is only one part of the financial picture for old people, it is important to note that 80% of homeowners 65 and older have paid off their mortgages.

The share of wealth controlled by working-age Americans is eroding while the share controlled by elderly Americans is increasing. According to Howe and Strauss (1992), "since the early 1970s the overall stagnation in American economic progress has masked some vastly unequal changes in living standards by phase of life. Older people have prospered, Boomers (born 1946-1964) have barely held their own, and Thirteeners (born 1961-1981) have fallen off a cliff....Tax codes, entitlements, public debt, unfunded liabilities, labor laws, and hiring practices — have tilted in favor of the old and away from the young. Twenty years ago a typical 30-year-old male made 6% more than a typical 60-year-old male; today he makes 14% less."

A recent report from the Luxembourg Income Group, a group of academics and government statisticians from a dozen industri-

alized countries trying to develop valid cross-national comparisons of key economic conditions, found that elderly couples in the United States are the most prosperous of any in the Western world. In the mid-1990s, U.S. married couples 65 and over were, on average, by far the most affluent relative to their countrymen, with median incomes almost 10% above the U.S. family median. In contrast, the median income of older couples in the other countries ranged from 3% above the national family median in Germany to 30% below in Australia (*Wall Street Journal*, 1993).

The economic health of old people has improved greatly in the last three decades. In 1959, the poverty rate for the elderly was 35%; in 1986, it was 12%, or somewhere between 3% and 8% if you count "properly" the noncash benefits. Between 1984 and 1988, the net worth of the average 70- to 74-year-old householder increased by fully 20%.

This analysis indicates that elderly Americans control a substantial and increasing portion of the nation's wealth. With the real estate boom of the 1970s and 1980s, the stock market surge of the 1980s, lucrative pension and Social Security payments, and high savings rates, older Americans as a group have amassed a huge generational nest egg.

New Views of the Aging Process

Aging is viewed differently today. Frailty and decline are no longer seen as fixed variables, ones that we cannot change. To the contrary, there has been an explosion of new knowledge and interventions for old people. From hip and joint replacement to new interventions for heart disease, prophylactic exercise, diet, and psychotropic medications, all shape a new, very clear understanding that we can, to a degree never before contemplated, affect, shift, delay, and shape the aging process.

Because aging is no longer viewed as hopeless and inevitable, but rather as modifiable by the individual, people now desire control over the aging process. Our new activist inclinations are caused by and in turn create a new, higher expectation of all components of senescent (aging) lives — environment, lifestyle, physician services, exercise, food, and the like. As the aging process is teased away as a dependent variable, aging is decreasingly viewed as a "fact," as inevitable as death and taxes. One's aging is no longer "me," but is viewed as a discrete, modifiable process, separable from me. As a result, the older person becomes an aggressive consumer, and the entire field becomes a consumer-driven enterprise. The new client demands a longer life with increased satisfaction for less cost.

Woven into this rich tapestry of rising expectations and shifting responses is the extraordinary new wealth and greater sophistication of the new cohorts of older Americans. These octogenarians, nonagenarians, and centenarians have raised a highly educated, professional cohort of Jewish children who are now active participants and partners in the consumer-oriented selection process of services and settings for their parents.

New Views of Governmental Entitlements

However, there are troublesome aspects of the new service demands of these two generations. Both adults and children hold new, more comprehensive understandings of a relatively new form of asset in America, the entitlement. In our postindustrial, information-based economy, entitlements are viewed as commodities. Supplementary Security Income, Medicaid, and food stamps, for example, originated as humanitarian gestures and were really artificial grafts onto a body of societal traditions and laws that did not tolerate such obligations. Now these programs are viewed outside of their original context.

These new perceptions are an outgrowth of the most imaginative and startling growth in the post-World War II era — the explosion of new rights, rights enacted not only through legislation but also through

the enormous development of administrative law. From the GI Bill to VA-enhanced mortgages, the current aging generation and their children have come to view these "entitlements" as rights, ones that can and should be expanded to the fullest extent under the law, much as one would exercise First Amendment rights. As a new form of property, these entitlements become a silent economic backbone for individuals and families. For example, an entire industry of planners and consultants has arisen to counsel middle-class families on how to shift assets legally and hold down reportable income, enabling them to qualify for governmental aid for their children's education. Families are learning to shape their behavior; to move, buy, or sell homes; and to invest or spend with a primary purpose of capturing and/or enhancing compensation from government.

Because most of these entitlements have developed neither systematically nor from a philosophical groundwork of acceptance by the populace, the result is a crazy patchwork of programs that are endlessly tinkered with and expanded by exception and anomaly.

Our sense of the individual's relationship with government and institutions has changed dramatically — from a sense of community and obligation to the commonweal to a new, every-expanding series of demands of government. It is consumerism in its purest form. The focus is no longer on the productive capacity of the institution or the organizations that comprise the delivery system (the supply side), but rather on the end-users' demands and expectations.

Ironically, the government is itself leaping on to this bandwagon. Rather than working with nursing homes to increase reimbursement and strengthen delivery systems, government is now becoming partners with the consumer and with the anti-nursing home consumer coalitions that demand more stringent regulation and more sophisticated systems of surveillance.

Jewish Communities' Participation in the Consumerism Movement

It is within this overall context that we can now understand the pressure points, the real dynamics of the new aging system. And before attempting to seize the moral high ground and to criticize these atavistic practices that have deleterious effects on the overall system, we, as Jewish communities, must understand our own participation in and stimulation of these perceptions and practices.

In the 1960s and 1970s, American Jewish communities were very quick to build and expand their entire aging systems on the back of and around governmental programs, using but a sprinkle of community seed money. Jewish communities built nursing homes using Medicaid and Hilburton funds and housing for "independent" old people using federal 202 and 236 capital with Section 8 rent subsidy money. Older Americans Act funds were used to develop senior centers, nutrition sites, and meals-on-wheels programs. Today, these systems based on a tiny bit of community funds have blossomed into a $1½ billion-a-year Jewish aging industry. In effect, the organized Jewish community has played "consumer" with the government and has modeled consumer behavior quite effectively to its constituent community members. As described in *Spirals*, this system worked extremely effectively for a decade or two. However, the sheer increase in numbers and the epidemiological shift of old people have made that system fall of its own weight.

New Government Posture

Because old people now live so long and are so frail, the costs of caring for them have become untenable, even for the government, which has the power to tax. Ironically, the safety valve for government is the new wealth of the aging. As long as the elderly were viewed as poor immigrants living and dying in desperate circumstances, the gov-

ernment and societal commitment to the aging remained unchallenged. Yet, with the new affluence of older people and altered societal perceptions (see the "Greedy Geezers" cover of *Time* (1993) magazine), the special protection afforded to the aging as a "suspect category" is being lifted.

The intergenerational equity debate is but a distillate of the growing recognition that it is now ethically and politically supportable to shift support for old people to other groups. Building on the new affluent aging image, government can develop tighter reimbursement methodologies and cost-saving measures.

The Paradox

The central paradox is that as the government withdraws its support from caregiving facilities, it simultaneously aligns itself with the consumer. First, it takes the role of protector of old people and families from the destructiveness of a powerful proprietary industry. Second, even as government extricates itself from its financial obligations to the facility and demands that the facility respond to the consumer, the government does *not* allow the facility to pursue the consumer (the old person and family) to replace governmental funds with family (even wealthy family) funds. The fiction remains — the child is not responsible for the parent.

And the family funds that could be used to pay for care are enormous. An economist recently estimated that older Americans as a group:

> have amassed a nest egg valued at $5.3 trillion–an average of $250,000 for each household headed by a person over 64. Those assets mean an unprecedented windfall for many otherwise struggling younger Americans. The money is already flowing fast: the share of total household net worth derived from inheritances and family gifts jumped from 47% in 1962 to 71% in 1989, according to Wolff. "This is radical turnaround," he says. "People used to support their parents in old age. Now the elderly are supporting their children and in many cases their grandchildren ("Waiting for the Windfall," 1993, p. 50)

The power of this drive to preserve assets has spawned a whole new industry — the elder law business — the goal of which is to "preserve" (really transfer) assets. The moral, ethical foundations of such transfers are weak and are usually "backed into" with "rights" and "entitlements" argumentation. Yet, because this transfer program has become a *de facto* part of the societal expectation of government, the normal loopholes through which these assets disappear are not closed.

In one of the more popular books of the elder law industry, *How to Protect Your Life Savings from Catastrophic Illness and Nursing Homes,* Harley Gordon (1991) explains several strategies to make an older person's assets inaccessible to a nursing home. He writes, "Believe it or not, these things can be worth hundreds of thousands of dollars but Medicaid has chosen not to count them to determine eligibility." They include a house used as a primary residence (can be protected by giving away the house while retaining a life interest, by putting it in trust, or by holding the house jointly, a car, and personal jewelry. Other assets can be made inaccessible by giving them away, holding them in Medicaid trusts in which the discretion of the trustee is limited, and holding them in certain types of joint accounts.

This *de facto* policy allows/encourages old people to transfer the financial burdens of their old age onto the government, thereby protecting their nest egg, which they can transfer intact in the form of a windfall to their children.

However understandable the history and logic of this paradox, which is now policy, even more pernicious and convoluted is how this has become a *de facto* Jewish communal policy. Ironically, it was the Jewish community itself that modeled and indi-

rectly trained its community members in this behavior. When Medicaid and Medicare legislation was passed, Jewish communities were extremely sophisticated and marshalled their resources to get government to fulfill the Jewish community's historical obligations to care for its aging. Not only did the organized Jewish community model the behavior but it actually encouraged the transfer of assets of its community members, ostensibly so those funds could be given to federation for other communal problems.

The technical maneuvering to shift responsibility is policy at the highest level. Or rather there is no overarching policy, but only shifting ploys that constantly are reshaped by technical legal artifice. The result is that the long-term care arena is built not on firm principles, but has evolved to a framework of perpetual gamesmanship, a game of tag where the key to survival is not to be "it."

The "transfer" phenomenon is at the heart of the aging system. We must therefore face it squarely as a given, as a phenomenon that we must understand and incorporate into all of our plans. For despite the fact that government has shifted its reimbursement streams, making the transfer pattern destructive to the facility as well as to the underlying community itself, communities have not changed this pattern of behavior. Consider these explanations for why this behavior persists

- It is within the child's "rights."
- Putting Mom on Medicaid has become a statement of how clever the child is and how connected he or she is to expert legal and accounting advisors.
- It indirectly displays how successful a son or daughter is compared to much humble beginnings. It ties the child to the myth of the Horatio Alger story.
- As the home and the federation accepted more government funds and began to take on the coloration of government, Jews began to respond to their own facility and community as they have to government — as an oppressive bureaucracy that is so ponderous and unresponsive that the individual is virtuous in standing up to it or going around it. Community can now be viewed as "other," to be manipulated in order to survive, as Jews on the edge have always done to distant, mindless bureaucracies. The home and federation are viewed merely as intermediaries, conduits for the governmental entitlements. As a result, pure consumer behaviors prevail.
- We have developed highly sophisticated abilities to compartmentalize — to deal with a range of conflicting images and experiences; to deflect, select, open, and shut one's mind; and to separate inconsistent sets of obligations, allowing them to coexist. These skills have become critical to survival in a morally ambiguous, complex world. In effect, one learns to act even while cognizant of the socially destructive patterns of those actions, while still retaining an internal sense of moral justification.
- Finally, many of our Jewish communal leaders, lay and professional, have fallen behind under the weight of changing regulations, demographics, reimbursement systems, and expectations. Rather than developing new worlds and systems that address the new realities more effectively and efficiently, many have just held tighter to the old. We have hobbled community discussion, constricting it by guilt, obligation, and *shanda*, hoping to protect our institutions from the encroachments of a new world, rather than lifting the entire Jewish communal paradigm into new, flexible and, yes, risky endeavors.

There is risk in attempting to develop new, more representative, appropriate sets of buildings and services for aging. Rather than stepping up to the challenge, we hunker down into the embattled Medicaid mentality, clamoring intermittently for

more governmental Medicaid funds or for the de facto policy of asset transfer to be eliminated. While caught in this cycle, the community is held captive to old worlds and images. In doing so, all players continue in their old modes: the federation is pressured for more subvention through its planning and allocations, families continue to strip assets and place Mom on Medicaid, and the home continues to drown. In summary, the death spiral, which is the only logical result from these behaviors, becomes inevitable.

The power of inertia is perhaps the greatest hurdle. Tolstoy wrote:

> I know that most men, including those at ease with problems of the greatest complexity, can seldom accept even the simplest and most obvious truth if it be such as would oblige them to admit the falsity of conclusions which they have delighted in explaining to colleagues, which they have probably taught to others, and which they have woven, thread by thread, into the fabric of their lives (quoted in Davidson & Rees-Mogg, 1991, p. 211).

The historical perceived self-interest of the government, the old person, the family, the Jewish home, the Jewish community, and the Jewish communal professional has led each to follow their perceived short-term best interests while the overall system dies.

IMPLEMENTING THE NEW PARADIGM

The new paradigm must recognize that under the existing legal framework it is not possible to *push* people into new behaviors, but rather they must be *pulled* — pulled by new sets of services, buildings, options, and services that are so attractive that people will be willing to change their behaviors. It must be built to encourage the "new consumers" to remain in the least expensive, most appropriate, most residential setting as long as possible (gerontological laws) and then to use their actual assets to invest in their own care (laws of self-interest). The various components of the campus must be sized and shaped to induce old people and their families to pay the actual cost of their own care (organizational laws).

From the vantage point of the new paradigm, it becomes apparent that our problems are self-induced. The solutions developed in the old paradigm have themselves become problems that can only be resolved by a new paradigm.

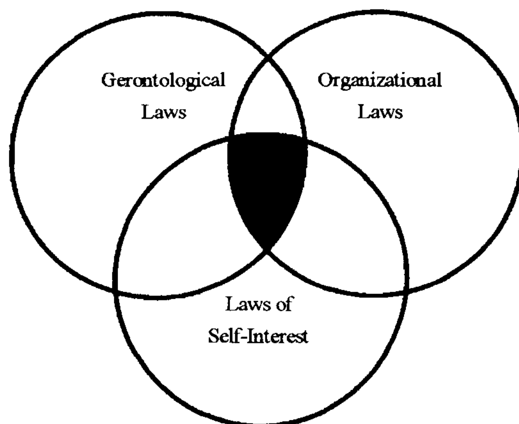
There must be a recognition of the new realities. The government does not have funds. Federation is but a vehicle and has no funds. And surely Jewish aging facilities have no funds. Old people and their families together have assets and are now capable of paying for their own care.

We must also recognize that Jewish families have become quite adept at shaping the placement, the form, and the perception of assets in order to garner the finest or most appropriate services at the lowest costs. Rather than chasing these assets, a Jewish aging system, through its buildings, its services, and its policies, must recognize the power of the laws of self-interest and encourage the assets to "reappear" to get the best deal.

Simultaneously, the Jewish community cannot walk away from its charitable mission and its obligation to those who are truly without resources. For those in its midst who are truly indigent, we must develop an endowment pool to pay for charitable care. When an individual applies for admission to the system, an application would be made to a special scholarship committee to determine whether this family should receive such a community subsidy. This is fair to the family. This is fair to the federation, which effectively has been giving scholarships after the fact through allocations from the general fund (to the institution rather than the scholarship recipients). And it is fair to Jews who have donated with the expectation that the funds will be received by those truly in need, rather than to their wealthy neighbor's family.

The system specifically articulates that families have an ongoing moral obligation

Figure 3. An appropriate admission to today's nursing home lies in the intersection of the three domains.



for their parents, an obligation that supersedes that of the community. And it recognizes that our communal aging systems and our underlying organized communities cannot continue to subsidize middle-class families, the preponderance of our population, and survive.

SUMMARY AND CONCLUSION

This article has attempted to break down, analyze, and reorganize the various aspects of aging into a new paradigm. Each of the various components — gerontological laws, organizational laws, and the laws of self-interest — has shifted and evolved so dramatically that the old paradigm no longer is functional. This new paradigm reshapes buildings, services, and clients into a new framework, one that will allow all participants to thrive. And it pushes further to redefine the responsibilities of community membership.

An appropriate admission to today's home lies in the shaded area in Figure 3, which is the intersection of the gerontological rules, the organizational rules, and the laws of self-interest. This approach reshapes the contours of the aging experience, the posture of a caregiving organization, and the perception of and commitment to the community.

REFERENCES

Barber, Joel Arthur. (1992). *Paradigms: The business of discovering the future*. New York: Harper Collins.

Cohen, Steven M. (1983). *American modernity and Jewish identity*. New York: Tavistock Publications.

Davidson, James, & Rees-Mogg, William. (1991). *The great reckoning*. New York: Summit Books.

Dunkelman, David M. (1991). The Jewish home in the year 2000. *Journal of Jewish Communal Service*.

Dunkelman, David M. (1992, Fall). Why a Jewish home. *Journal of Jewish Communal Service, 69*(1).

Dunkelman, David M. (1993, Winter/Spring). Spirals: The Jewish home dilemma. *Journal of Jewish Communal Service, 69*(2/3).

"Greedy geezers." *Time*.

Hailey, Godron. (1991). *How to protect your life savings from catastrophic illness and nursing homes*. Boston: Financial Planning Institute.

Howe, Neil, & Strauss, William. (1992, December). The new generation gap. *The Atlantic Monthly*, p. 78.

Hull, Jon D. (1993, January 18). Waiting for the windfall. *Time*, p. 50.

Waiting for the Windfall. (1993, January 18). *Time*, p. 50.

Wall Street Journal. (1992, July 20). p. B1.